



Medicaid – The Coming Crisis? Or, A Tool for Self-Sufficiency?

Medicaid is a joint federal/state program created under Title XIX of the Social Security Act of 1965. The program was originally intended to provide individuals who qualified for cash assistance the opportunity to receive health care through the same providers as the general public. However, 35 years of “tweaking” the system has produced a program in which eligible people choose not to enroll. There are a variety of reported reasons for non-enrollment. Some people would rather not deal with the bureaucracy. Some do not want government assistance and others do not need government assistance until they are ill. And then, there are some who are reported to be eligible, but do not meet the resource criteria. The time has come to accomplish the original goal of Medicaid – to provide low-income individuals the opportunity to receive health care through the same providers as the general public.

History

Texas began its participation in the Medicaid program in 1967. The federal legislation creating Medicaid made it a voluntary program for states, with the condition that if a state chose to participate, it was required to abide by all of the federal mandates, rules and guidelines governing the program. In addition to the mandatory benefits every state that participates must cover, the federal government also offers optional benefits for which a state may receive matching funds if it chooses to provide such services. However, optional benefits that a state may offer must also be administered by federal rules.

Medicaid is an entitlement program, which means that everyone who qualifies under federal guidelines and definitions is automatically eligible to receive benefits. The federal government does not, and the state government cannot (with the exception of specifically authorized waivers) cap the number of people who enroll or the amount of benefits it will pay. States are able to reserve the right to set eligibility criteria within certain parameters to ensure that services are provided to the most needy. However, regardless of the amount budgeted or the spending priorities of the Legislature, if Medicaid benefit payments exceed appropriations, the state must find the money to provide the services.

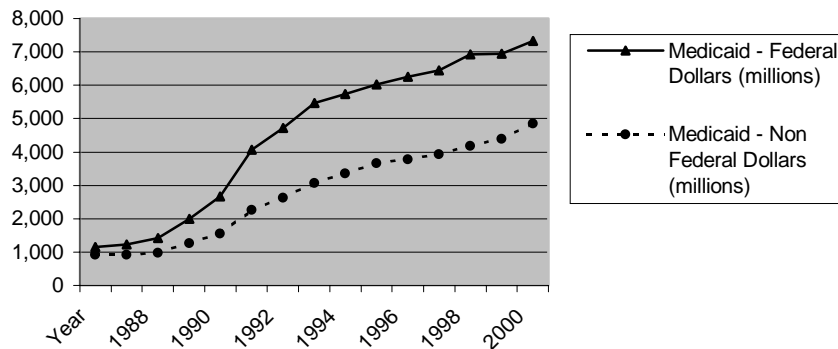
Some may wonder why a state would surrender such control of its budget to the federal mandates involved in the program. The answer lies in the enticement of federal funds. Because the federal government matches state expenditures for Medicaid benefits, states often find ways to expand services in order to draw down more federal money. In an attempt to shift the responsibility for indigent care to the federal level and to qualify for more money, the Legislature, over the years has increased eligibility, provided optional benefits and certified local funding sources to serve as a match for federal dollars. Of course, each time this happens, the state must also increase its budget and its requirement to provide services.

In 1999, the federal matching rate for Texas was 62.45 percent. That is, the state paid 37.55 percent of Medicaid costs while the federal government paid the majority of the remainder. However, reductions in the federal match (it is figured annually on a formula based on average state per capita income compared with the U.S. average) leave the state responsible for continuing to provide those expanded benefits, but with fewer federal matching funds. Because of the robust economy Texas has enjoyed in the past few years, the federal matching rate in fiscal year 2001 will be only 60.57 percent.¹ The state will be required to make up the difference with state revenues.

Fiscal Issues

It took the Medicaid program in Texas 20 years to grow to a \$2 billion budget item. In the 10 years between 1987 and 1997, the Medicaid budget in Texas increased over 400 percent, reaching the \$10 billion mark in 1997. Medicaid was 25 percent of all funds (state and federal) in the state budget for 1998-99 biennium, and 17% of state funds.²

Medicaid Expenditures³



According to *Texas Medicaid in Perspectives 1999*, a report released by the Texas Health and Human Services Commission, the explosive growth in the Medicaid budget had three driving factors:

- Increased enrollment caused by expansion of federal mandates,
- Medical inflation and
- Escalation of Disproportionate Share Hospital payments.

Increased Enrollment

In 1988, Congress dramatically expanded the mandatory eligibility standards for Medicaid recipients. Programs created or expanded due to that expansion of eligibility included:

- Coverage of prenatal and delivery services for certain pregnant women and their infants who had no other insurance,
- Expansion of services to many children in low-income families who do not receive cash assistance,
- Expansion to fill gaps in Medicare services to poor persons who are elderly or disabled and
- Coverage of all federally allowable Medicaid services as medically necessary and appropriate for all children on Medicaid.⁴

Medical Inflation

Medical care is one of the major items within the Consumer Price Index (CPI) that is used annually to determine the national rate of inflation. The costs of medical care services such as professional services, hospital services, prescription drugs, non-prescription medical equipment and supplies are considered when calculating the medical inflation rate. It is projected that the nation's total spending for health care will increase from \$1 trillion in 1996 to \$2.1 trillion in 2007.⁵ During that time frame, health care spending as a percentage of the gross domestic product (GDP) is expected to increase from 13.6 percent to 16.6 percent.

The increase in expenditures in medical costs is caused both by inflation (an increase in the price of a particular product or service) and utilization (an increase in demand for a particular product or service). Managed care was once considered a potential solution to the over-utilization of services. However, after a brief respite from rising prices for health care benefits in the private sector, costs are once again on the rise. Aetna, the largest U.S health insurer has announced it will raise premiums an average of 13 percent to cover its drop of 17 percent in second quarter profits.⁶

In another effort to help counter the high medical costs, the Texas Legislature passed a tort reform package in 1995 that included medical malpractice reform. This measure resulted in a 17.2 percent reduction in the cost of medical malpractice insurance, with a five-year savings to consumers of \$217.3 million.⁷

Escalation of Disproportionate Share Hospital Payments

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such facilities are known as Disproportionate Share Hospitals (DSH) and receive disproportionate share funding. In 1998, 166 Texas hospitals qualified to receive DSH funding.⁸ These funds are an important source of revenue for Texas hospitals and are used to defray the cost of treating the indigent, recruit physicians and other health professionals, obtain equipment and renovate facilities. Funding for the Texas DSH program was capped by federal law in 1991 at \$1.513 billion. While funding has been stable since 1991, changes due to the Balanced Budget Act (BBA) in 1997 will cause DSH funding to decrease in the years 2000 – 2002. Those reductions will affect DSH hospitals across the board and the cost of providing services are likely to be shifted to state and local governments, as well as other for-profit and not-for-profit hospitals.

Managed Care

At the direction of then Lt. Governor Bob Bullock, Texas legislators embarked upon a mission to reform the state's Medicaid program in an effort to control rising costs while maintaining quality care. In 1991 the Legislature approved two Medicaid managed health care pilot programs – one in Travis County and the other in the Gulf Coast area.

By fiscal year 2000, 29 percent of Texas Medicaid clients and most of the State's major urban areas were in managed care.⁹ According to the Health and Human Services' *Medicaid Managed Care Report*, managed care had achieved savings of \$92,650,000 for State Fiscal Years 1997-1999. The report further stated that, in general,

access had improved, inappropriate utilization of services has decreased and processes to monitor and assure quality improvement are in place. Under Medicaid Managed Care (MMC), the State has a structure for improved program monitoring, oversight, accountability, and outcomes that did not exist in the traditional Medicaid program.¹⁰

Medicaid managed care has proven to be an effective tool in increasing competition for the performance of health care services. As private for-profit and non-profit hospitals begin to vie for the opportunity to offer services, the quality of the services should increase while the cost should decrease. At the same time, the data collection systems necessary to determine the effectiveness of care coordination programs and establish accountability for health outcomes are being implemented. The long-term success or failure of a managed care model for delivery of Medicaid services in the state will be dependent upon the state's ability to shift from claims payment and regulation to using the market and competition to achieve public policy goals and using contracts to hold Managed Care organizations (MCOs) accountable for improved performance.¹¹

Looking Forward

The double-digit budget increases in Medicaid experienced in the early 1990s slowed to a rate of increase of only 5.6 percent per year from 1995 to 1997. The private sector's response to medical inflation that led to increased use of managed care systems held down the cost of both private and public health services. At the same time, a strong state economy and welfare reform served to reduce the enrollment of Texans for Medicaid services. The 77th Legislature should carefully consider the implications of any proposals to expand Medicaid eligibility in light of court cases, spillover from CHIP and projected demographic changes.

Frew vs. Gilbert

In October, the Fifth Circuit Court of Appeals stayed an August 14th order by Judge William Justice to produce a corrective plan within 60 days to comply with a 1996 consent decree in the *Frew vs. Gilbert* lawsuit. That case, filed in 1993, challenged the state because of its failure to fully implement the Texas Health Steps (THSteps) program that provides health care for Medicaid enrolled children. According to the Texas Department of Health (TDH), the state has been pursuing improvements in providing services. Currently, 66 percent of Medicaid eligible children are receiving regular check-ups, a significant increase over the 29 percent of eligible children who received those services in 1993. Also, in 1993, the state provided transportation for 743,000 Medicaid eligible trips to the doctor. That number has risen to 2.5 million trips in 2000. The TDH indicates that efforts to deliver services to all eligible patients will continue, which indicates that these numbers will continue to grow.¹²

The *Frew* decision fundamentally changed the role of the government in the lives of Medicaid eligible children. Rather than parents being responsible for making sure their children receive appropriate health care, the decision shifted that role to the government. It is not sufficient that the state have an appropriately run and financed program. It has now been made responsible for both the provision of services and for the response of potential recipients of those services. Testimony was offered during the case that "60 percent of respondents reported knowing only 'very little' or 'nothing at all' about the program."¹³ A parent's lack of knowledge about the THSteps may or may not be the fault of the state. However, it is always the responsibility of the parent to seek appropriate health care for their child.

CHIP

The Children's Health Insurance Plan (CHIP) is a program to initiate and expand the provision of children's health insurance to uninsured, low-income children. Children in families with a net income at or below 200 percent of the federal poverty level are eligible for the program. The definition for "net family income" includes offsets for such expenses as childcare, work-related expenses and other deductions consistent with Medicaid standards.¹⁴

Of the approximately 1.4 million Texas children who are reported to be uninsured, it is estimated that 600,000 of them are potentially eligible for Medicaid coverage. Federal law prohibits an individual eligible for Medicaid to enroll in CHIP. However, in the process of applying for CHIP, applicants are screened for Medicaid eligibility and referred for enrollment in that program. It is noteworthy that, so far, Medicaid enrollment has not increased at the rate that might be expected, given the number of referrals from CHIP. In fact, through October 24, 2000, 16,964 referrals for Medicaid from CHIP had been denied because the family failed to keep an appointment to establish eligibility. In other words, 16,964 applicants had applied for coverage in a program where they would share premium costs but, when referred to the "free" government program, they declined to participate in the process. This would seem to indicate that there exists among many lower income families a desire to take some responsibility for their own healthcare, rather than becoming dependent on government programs. An even stronger indicator that families desire to take personal responsibility for their health care needs is the fact that 1,853 applications for CHIP coverage were from people already enrolled in and receiving Medicaid. Legislators would do well to take note of this desire when designing future programs.

Demographic Changes

The potential for 600,000 new Medicaid recipients in the under 19-age bracket as a result of CHIP screening is only one concern of the Medicaid program. At the other end of the spectrum, population projections indicate that the over 65-age bracket will increase 9.3 percent by 2005 and 107.7 percent by 2025 as a result of the aging of the baby boomers.

Texas Medicaid pays for a portion of more than 70 percent of all nursing home residents.¹⁵ Additionally, Medicaid funds, or partially funds:

- Community Care Services as a cost-effective alternative to institutionalization,
- Primary Home Care to assist the individual with daily living activities,
- Frail Elderly Program to allow personal care without other Medicaid benefits to individuals with incomes too high to qualify for Medicaid,
- Day Activity and Health Services as an alternative to nursing homes or other institutions, and
- Hospice for individuals who have been diagnosed as terminally ill.

While the elderly population accounts for only 12 percent of the Medicaid population, they account for 30 percent of the expenditures. Considering the projected spike in the elderly population within 25 years, fiscal plans should begin now to accommodate the growth.

Conservative Note

The advent of managed care and the Texas tort reform package have both worked to slow the rate of medical inflation in Texas. That decrease in inflation, though driven by the private sector, benefited the public sector as well in helping to keep down the cost of services. At the same time, the successful economic status of the state has allowed the exorbitant cost of the federal expansion of eligibility for Medicaid to be absorbed into the state budget without critical reductions in other service areas. While it may seem to some that the storm is over, legislators should beware that the current lull in increases in Medicaid spending is only the eye of the storm passing over.

The demographic projections in the state for the elderly, coupled with the disproportionate share of Medicaid spending for that population as a percentage of recipients; the potential for identifying and enrolling an additional 600,000 Medicaid eligible children through the CHIP screening process; and the increase in medical costs due to both medical inflation and increased utilization could all converge on the budget in the next five to 10 years, having a significant effect on state finance. At the same time, there are recommendations in the Senate Health Committee Interim Report to further increase eligibility to Medicaid by eliminating the face-to-face interview requirements, eliminating the assets test for children and increasing continuous eligibility from 6 to 12 months for children's Medicaid.

The last time the state faced double-digit medical inflation and large enrollment growth was during the time when expenditures for Medicaid increased 22 percent a year with a 400 percent increase over 10 years. The majority of that increased enrollment was due to federal mandates. Once again, the state is facing a scenario that could result in high increases in the state Medicaid budget.

If increased enrollment results due to changing demographics and increased eligibility, for Medicaid eligibility and with the early warning signs that medical inflation may once again be on the rise, the potential for a repeat of that type of growth should be considered. With an increase of only 22 percent in Medicaid expenditures over the next five years, the state could experience annual expenditures of over \$30 billion a year by 2005. The money for this program will either come as a result of increased taxation or re-prioritization of other state programs, unless the tide is turned.

There is no question from any side that the benefits offered by Medicaid represent a worthy goal. However, there is a difference in philosophy regarding how the problems should be solved. On the one hand, some believe that the state policy should be to dramatically increase

the number of persons enrolled in Medicaid in order to ensure that they have access to health care services. Proponents for expanded Medicaid eligibility believe that if you just make the eligibility system easier more people will use the services.

Others argue that the way to address the issue is not by growing government, but rather by:

1. increasing an individual's ownership in their own health status;
2. embracing an individual's desire to become and remain self-sufficient; and
3. empowering individuals through education.

That should be done by first, within the existing Medicaid delivery system, cost-sharing mechanisms should be implemented to increase recipients' use of primary and preventative care and discourage the inappropriate use of emergency rooms. Second, within both CHIP and Medicaid, recipients should allow or increase subsidies for the purchase of employer-sponsored plans. Additionally, the state should test through a pilot project allowing low-income Texans to use a Medical Savings Account as a means to access health care and encourage savings. Third, public health and welfare education programs should be focused on increasing knowledge of healthy practices and lifestyles. And finally, Texas should work at the federal level to change the delivery system for medical assistance to allow for the use of a sliding-scale to help bridge the gap between government-designed health plans and employer or individual health plans.

¹ *Federal Financial Participation in State Assistance Expenditures for October 1, 2000*, Federal Register, Volume 65, Number 46, 23 Feb. 2000, pgs. 8979-8990.

² State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), 74.

³ *Ibid.*

⁴ *Ibid.*, 21.

⁵ Health Care Financing Administration, *Highlights of the National Health Expenditure Projections, 1997-2007*, www.hcfa.gov/stats/nhe%2Dproj/hilites.htm, accessed November 8, 2000.

⁶ *Health Inflation News*, Vol. 9 No. 8, 25 August 2000, p. 1.

⁷ Texas Department of Insurance, "Tort Reform Savings Total \$2.9 Billion," press release, October 1, 1999.

⁸ State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), 65.

⁹ Health and Human Services Commission, *Medicaid Managed Care Report (Draft Version)*, www.hhsc.state.tx.us, (October 2000) Chapter 1 p. 1.

¹⁰ *Ibid.*, Chapter 1 p.1-2.

¹¹ *Ibid.*, Chapter1 p. 2.

¹² Mr. Doug McBride, Public Information Officer, Texas Department of Health, conversation with author, October 30, 2000.

¹³ *Frew vs. Gilbert*, 2000 WL 1206458 (E.D.Tex).

¹⁴ *State Child Health Plan Under Title XXI of the Social Security Act: State Children's Health Insurance Program*, <http://www.hhsc.state.tx.us/ipisi/spasb445fin2.pdf> .

¹⁵ State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), p. 63.