ESSAYS ON ISSUES

THE FEDERAL RESERVE BANK OF CHICAGO

MAY 2007
NUMBER 238a

# Chicago Fed Letter

## A Forum on Medicaid and State Budgets: A summary

*by Richard H. Mattoon, senior economist and economic advisor*

When it comes to state budgets, the Medicaid program is almost always the proverbial 800-pound gorilla in the room. On March 15, 2007, the Federal Reserve Bank of Chicago and the Civic Federation co-sponsored a forum to discuss the growing cost of Medicaid and how states are responding.

Materials presented at the forum are available at www.chicagofed.org/news_and_conferences/conferences_ and_events/2007_medicaid.cfm.

**For** almost every state in the U.S., the Medicaid program, which provides health care coverage to 41 million families and 14 million elderly and disabled people, is the largest single budget item. It is often seen as the source of considerable budgetary stress. This forum on Medicaid and state budgets brought together top researchers and government leaders to discuss funding and policy issues as well as best practices.

The first speaker, Robin Rudowitz, principal policy analyst, Kaiser Family Foundation, focused on the evolution of the Medicaid program and the impact of the most recent legislative changes. Each year, the foundation surveys all 50 states to track how they are managing their Medicaid programs and how these programs impact their budgets. Rudowitz noted that Medicaid costs are driven chiefly by elderly and disabled enrollees, who account for 25% of the total enrollees but 70% of the total expenditures. In fact, just 4% of the Medicaid population consumes 48% of all expenditures. Medicaid is the largest single source of federal funds to the states, representing 44% of the total.[1] The states' own-source revenue to pay for Medicaid equaled 18% of their general fund spending in 2005.

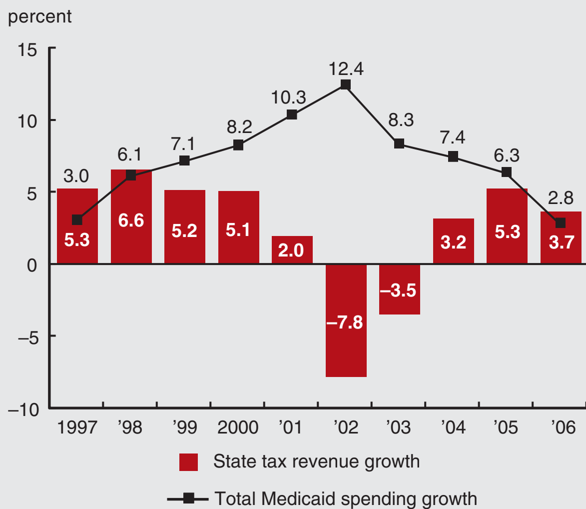
In 2006, Medicaid spending growth was below state revenue growth for the first year in a decade (see figure 1). Rudowitz suggested three reasons for this: the low rate of growth in enrollment; the enactment of Medicare's Part D prescription drug program, which moved dual eligibles off of Medicaid and onto Medicare for drug coverage; and state cost containment strategies. Although total Medicaid spending growth was held to 2.8% in 2006, the state portion increased by 6.8%.

Rudowitz concluded that Medicaid costs will continue to be driven by increasing health care costs, as well as an increasing pool of the uninsured as employer health care coverage declines. Demographic changes also imply a rising number of aged and disabled people. Another trend fueling Medicaid growth is that states are looking to develop universal health care plans and are using Medicaid as a platform for expanded coverage. Finally, federal policy will play a role, particularly through the new requirements for citizenship documentation to qualify for Medicaid and the current debate in Congress to reauthorize the State Children's Health Insurance Program (SCHIP).

### Time for a new approach?

Robert Kaestner, professor of economics, University of Illinois at Chicago, talked about the need for Medicaid and public health insurance to be redesigned. Kaestner noted that public spending is

**1. State tax revenue and total Medicaid spending growth**




NOTES: State tax revenue data are adjusted for inflation and legislative changes. Values for 2006 are preliminary estimates.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results From a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007*, report, No. 7569, October, available at www.kff.org/medicaid/7569.cfm.

often allocated to provide health insurance coverage rather than to directly improve public health outcomes. This is in spite of the fact that most studies suggest a weak link between health insurance coverage and healthier people. Kaestner also noted that the fiscal burden of providing this coverage will continue to grow fast. In Illinois, Medicaid already accounts for 25% of all income and sales tax revenue and 20% of all state revenue.

A primary goal for any redesign would be to lower the rates of medical utilization by enrollees. In his own research on utilization of medical services based on insurance status, Kaestner has found that publicly insured individuals tend to use more health care than individuals with similar characteristics who are either privately insured or uninsured (figure 2). Given this, he noted that reform has focused on supply side rationing. One method is simply to offer low reimbursement rates for Medicaid providers, although this likely leads to a lower standard of care. A more positive approach is the increased use of mandatory managed care with full risk reimbursement and narrow provider networks. An additional problem, he said, has been the tendency to extend Medicaid coverage to families with incomes at 200% of the poverty level or more, which has the effect of crowding out private insurance coverage. Kaestner argued that a state goal of universal health care coverage was unrealistic given state revenue constraints.

Another promising approach, Kaestner said, is to obtain a federal waiver to redesign Medicaid programs to better match the service needs of the recipients. South Carolina is developing customized insurance programs that reflect the health issues facing its targeted population, rather than offering a one-size-fits-all health plan. Finally, Kaestner argued that spending on public health should be increased given the large returns that preventive health care can provide.

Matt Powers, principal, Health Management Associates, discussed how states have taken the lead in expanding health care coverage, as some have even taken to adapting Medicaid as a platform for universal coverage. Powers noted that Medicaid remains the workhorse of the health care system. The challenges facing Medicaid, he suggested, stem in part from the expansion of the program to broader populations, as well as the considerable difficulty and complexity of implementing changes in health care provision and management. Given these challenges, some states may think it is just best to wait until the federal government offers a national health plan. Similarly, state policymakers may question whether it is worth the effort to develop their own plans if these will ultimately be trumped by federal policy.

State health care information systems also need to be improved. Powers noted that when he was Illinois's Medicaid director, information on health outcomes was hard to come by. Policymakers need to know whether they can control costs while expanding coverage. Finally, states must demonstrate that reliable revenue streams exist to cover these program expansions.

### Federal perspective

Ruth Hughes, technical director, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (HHS), described the value-driven reform effort that is at the heart of HHS Secretary Michael Leavitt's health care initiative. The aims are to provide the states with better health and price information and to create positive incentives for high quality health care purchases. Hughes stressed that improving the transparency of health care data is critical to better management.

In reviewing developments in health care reform in the Midwest, Hughes noted that virtually all of the states in the region have followed three strategies. First, they have instituted outreach programs aimed at enrolling eligible populations in Medicaid and SCHIP. Second, they have expanded their Medicaid programs to reach higher-income populations. And third, they are using federal waivers to cover specific populations.

According to Hughes, several federal initiatives included in the Deficit Reduction Act of 2005 have provided the states with greater flexibility while promoting personal responsibility for healthier lifestyles. For example, the act allows states to provide specific groups with alternative benefit coverage that better meets their medical needs. As part of the act, up to ten states may operate demonstrations to test alternative systems for delivering their Medicaid benefits, such as health opportunity accounts. These accounts are designed to enable patients to take greater responsibility for their health outcomes, as well as provide enrollees with better health education. There are also provisions to support the movement of individuals out of institutional care and into community settings. Studies have shown that community-based care is preferred, but transition costs of moving patients out of institutional

**2. Children's use of health care, by health insurance status**

| | Publicly insured vs. privately insured (percent difference) | Publicly insured vs. uninsured (percent difference) |
|---|---|---|
| No. of visits to medical professional in last two weeks | +26 | +51 |
| No. of overnight stays in hospital past 12 months | +18 | +27 |
| No. of visits to emergency room past 12 months | +23 | 0 |
| Saw a specialist past 12 months | 0 | 0 |
| Had a well child visit past 12 months | +5 | +24 |

Notes: The publicly insured are those covered by Medicaid and the State Children's Health Insurance Program. The sample comprises individuals aged 0–15 from families with an annual income of less than $45,000 in the 2005 *National Health Interview Survey*. All values presented here have been controlled for gender, age, race/ethnicity, health status, nativity, citizenship, family structure, family income and poverty ratio, mother's education, and region.

Source: Robert Kaestner, 2007, "Redesigning Medicaid and publicly provided health insurance," presentation at Federal Reserve Bank of Chicago and Civic Federation joint forum, A Forum on Medicaid and State Budgets, Chicago, IL, March 15.

care are significant. The act also provides several changes that increase state flexibility in managing long-term care programs and clarify what the individual's responsibility is for paying for long-term care. Hughes also noted that the act requires improved enforcement of documentation of citizenship for Medicaid applicants.

### State perspective

Barry Maram, director, Illinois Department of Healthcare and Family Services, described Illinois's past efforts to expand health care coverage and Governor Rod Blagojevich's recent proposal to provide statewide coverage. During the governor's administration, Maram said, the state's health insurance rolls have increased by 560,000 individuals. The state's fiscal management of Medicaid has also improved, according to Maram. The backlog of bills has been cut from $2.2 billion to $1.1 billion by FY2007, and the payment cycle has been reduced from 125 days to 50.

The governor's new universal health care initiative, Illinois Covered, will offer guaranteed, affordable private health plans to small businesses and individuals, and it will also give rebates toward the purchase of employer-provided health insurance to some families.

The program also aims to improve fiscal transparency and chronic disease management.

To pay for this health care initiative, the governor is proposing several new taxes.

The first is a payroll tax on businesses with ten or more employees that either pay very little or nothing toward the health care costs of their employees. The larger source of revenue will be a gross receipts tax on companies with more than $1 million in receipts. The tax rate will be 0.5% of gross receipts for sales, manufacturing, and construction companies and 1.8% for service providers. Companies will receive a 100% credit for corporate income taxes paid. It is estimated that this will raise $6 billion.[2]

Eugene Gessow, Medicaid director, Iowa Department of Human Services, talked about Iowa's innovative approach to managing its $2.6 billion Medicaid budget. Iowa has developed a system to track the type of health service the individual receives by using standard medical and billing codes in order to place Medicaid in the context of the broader health care system. The system generates information that is easily accessible and can be used by multiple audiences. System users can examine which program costs are controllable and whether the health needs of enrollees are being met. It also allows for closer examination of who is providing health care and what treatment is being received.

Iowa's system provides some interesting findings. For example, the use of emergency services is often cited as a significant cost to Medicaid programs. Yet, in Iowa, emergency service costs in 2006 totaled only $11 million out of a budget of $2.6 billion. In addition, 50% of the expenditures for emergency care were for individuals classified as having ailments of moderate or high severity, suggesting that these were appropriate uses.

### The future of U.S. health policy

In a keynote address at the forum, Tommy Thompson, independent chairman, Deloitte Center for Health Solutions, provided a structure for health care and Medicaid reform. Thompson is a former U.S. Secretary of Health and Human Services and four-term governor of Wisconsin. In his view, the U.S. health care system will reach a crisis by 2013. By that time, he said, health care spending will have doubled from current levels and will consume 21% of gross domestic product. At this level, U.S. businesses will not be able to compete because their health care burden will far outweigh that of their foreign competitors. For example, Thompson noted that even today General Motors' cost of health care is nearly $1,700 per car produced versus Toyota's cost of $225. In addition, by 2013, the Medicare system will start to go broke. Currently, Medicare runs a surplus and makes an annual contribution to the U.S. Department of the Treasury. This will not be the case starting in 2013.

Michael H. Moskow, *President;* Charles L. Evans, *Senior Vice President and Director of Research;* Douglas Evanoff, *Vice President, financial studies;* Jonas Fisher, *Economic Advisor and Team Leader, macroeconomic policy research;* Richard Porter, *Vice President, payment studies;* Daniel Sullivan, *Vice President, microeconomic policy research;* William Testa, *Vice President, regional programs and Economics Editor;* Helen O'D. Koshy, Kathryn Moran, and Han Y. Choi, *Editors*; Rita Molloy and Julia Baker, *Production Editors.*

*Chicago Fed Letter* is published monthly by the Research Department of the Federal Reserve Bank of Chicago. The views expressed are the authors' and are not necessarily those of the Federal Reserve Bank of Chicago or the Federal Reserve System.

© 2007 Federal Reserve Bank of Chicago
*Chicago Fed Letter* articles may be reproduced in whole or in part, provided the articles are not reproduced or distributed for commercial gain and provided the source is appropriately credited. Prior written permission must be obtained for any other reproduction, distribution, republication, or creation of derivative works of *Chicago Fed Letter* articles. To request permission, please contact Helen Koshy, senior editor, at 312-322-5830 or email Helen.Koshy@chi.frb.org. *Chicago Fed Letter* and other Bank publications are available on the Bank's website at www.chicagofed.org.

ISSN 0895-0164

Thompson argued that instead of resorting to traditional options, such as price controls, one-payer government health systems, or tax increases, the health care system should be transformed to promote healthier lifestyles and slower cost growth, with the following specific goals:

- Create a wellness system that encourages preventive health care and better lifestyles;
- Reduce chronic illness by changing human behavior. In particular, reductions in tobacco use, diabetes, and obesity would be targeted, with incentives for good health practices and disincentives for poor health practices;
- Improve management of the care of people who are really sick; and
- Adopt uniform standards for medical records (requires action by the federal government) and create a funding stream to pay for technology infrastructure. This would facilitate the development of electronic medical records that are portable and easily accessible to medical professionals, resulting in reductions in medical mistakes as well as administrative costs.

Thompson said state experimentation with Medicaid programs offers great promise. He suggested it may make sense to create an "uninsured" class of people and then allow private health insurance companies to bid to serve this population. Federal and state responsibilities should be split, he added, with the federal government providing for elderly and institutional care and the states providing acute, family, and wellness care. This would allow state Medicaid programs to focus more on preventive health care.

### Conclusion

Medicaid costs will continue to be a front burner issue for the states for some time to come. Driven by escalating health care costs and unfavorable demographics, the gap between states' revenue growth and Medicaid expenditure growth will persist without significant reform. At the same time, as fiscal pressures are being recognized, Medicaid is also being used in many states as the platform to promote universal health coverage, which will likely lead to even greater funding pressure.

[1] The Medicaid program is jointly funded by the states and the federal government. The amount of federal funds each state receives depends on its own Medicaid spending and its federal medical assistance percentage (FMAP). For more details on the FMAP, see http://aspe.hhs.gov/health/fmap.htm.

[2] These details are from the proposal in Governor Blagojevich's budget address of March 7, 2007. The proposal has since been revised.