Is Medicaid a High Cost Approach For Serving Low-Income Individuals and Families?

By John Holahan, Ph.D.
Director, Health Policy Research Center
Urban Institute, Washington, DC

The Medicaid population is much poorer and sicker and has more cognitive and physical limitations than the privately insured poor. When per person costs are compared directly, the costs for Medicaid adults are higher than for the privately insured poor ($4,877 compared to $2,843). However, when adults with fair or poor mental health or any physical limitations are excluded, spending for non-disabled Medicaid adults ($1,752) is significantly lower than for non-disabled poor adults who are privately insured ($2,253). Services provided by the Medicaid benefit package that are often considered too generous—dental and other optional services—add about 12% to total costs.

States are dealing with the most serious fiscal crises since World War II. State revenues declined in 2001 and for the most part have not kept pace with increasing demands on state coffers.[1] At the same time, states have been faced with shortfalls in elementary and secondary education budgets, increased demand for higher education because of the baby boom echo, and sharply rising Medicaid expenditures.

Between 2000 and 2003, national Medicaid spending grew about 10.2% per year.[2] In Wisconsin, Medicaid has grown an average of 13.0% annually during this same period. Taken together, plunging state revenues and upsurging costs have made Medicaid a topic of debate in state legislatures across the country.

Between 2000 and 2003, Wisconsin's Medicaid costs grew an average of 13% annually.

This chapter will cover why costs are increasing, why costs are so difficult to contain, who is covered by Medicaid, whether Medicaid is a Cadillac program, how cost effective Medicaid is, and what questions policymakers can ask to guide difficult Medicaid budget decisions.

Why Are Medicaid Costs Increasing?

Medicaid costs are being driven by the same pressures that are causing increases in private insurance costs—rising prescription drug costs, hospital price increases, and provider consolidation. Costs are also rising because of increased enrollment and increased spending per enrollee. The Medicaid enrollees who cost the most to treat—those with severe disabilities and the frail elderly—are growing faster than their rate of growth in the U.S. population. Why the aged and disabled are rising so rapidly in Medicaid is not well known, but this trend is expected to continue throughout the decade. This growth could be due to life-saving medical technologies that lengthen life, but leave people with disabilities. The high cost of prescription drugs may make Medicaid more attractive, and their use may contribute to the longevity of people with conditions such as HIV/AIDS. Increased enrollment in Medicaid home- and community-based care may

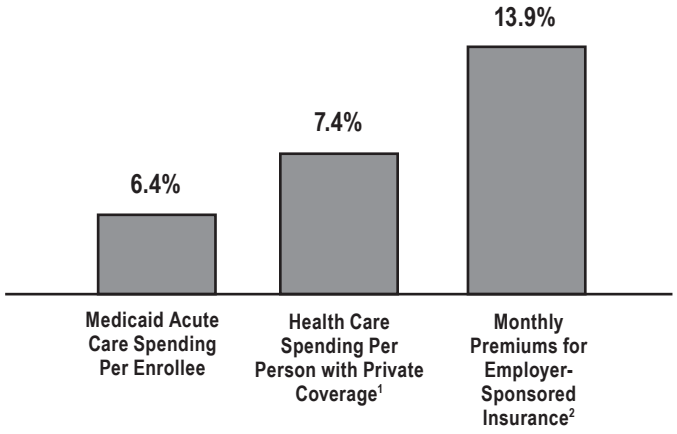
be a factor, and the baby boomers are approaching 55 to 64 years of age, a time when disabilities are likely to appear.[3,4]

Between 2002 and 2003, per person spending grew 6.4% for Medicaid, 7.4% for private coverage, and 13.9% for monthly employer-sponsored premiums.

Medicaid has also faced increased pressure because of the widespread decline in employer-sponsored insurance. Between 2000 and 2003, employer coverage for the nonelderly dropped 3.9% from about 68% to 64%.[5] About 5.1 million people lost insurance, but adults and children fared differently. Overall, the number of uninsured children *dropped* slightly due to increases in Medicaid and the State Children's Health Insurance Program (SCHIP) coverage. On the other hand, the number of uninsured adults grew 2.4% at a time when Medicaid enrollments increased only 2%. Thus, some adults were able to find other forms of coverage, but this was not enough to offset the decline in employer-sponsored coverage.[6] In 2003, 9.0% of Wisconsin's population was uninsured for some or all of the year.[7]

Despite these pressures, Medicaid spending grew more slowly than spending for private or employer coverage. Between 2002 and 2003, per person spending costs for Medicaid grew 6.4% compared to 7.4% for private coverage and 13.9% for monthly premiums for employer-sponsored health insurance.[8]

Figure 1: Medicaid's Growth in Spending was Less Than for Private or Employer Coverage (percent increase from 2002 to 2003)



[1] *Strunk, B.C. & Ginsburg, P.B. (2004, June). Tracking Health Care Costs: Trends Turn Downward in 2003. (Data Bulletin No. 27). Washington, DC: Center for Studying Health Systems Change.*

[2] *Gabel, J. et al (2004, September/October). Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage. Health Affairs, 23(5): 200-209.*

Why Are Medicaid Costs So Difficult to Contain?

Medicaid has proven a thorny issue for state policymakers to grapple with. Medicaid is a huge burden on the budget, but it also brings huge benefits to citizens in the state by providing mandatory and optional services. Nationwide, about 60% of Medicaid expenditures in 2001 were for people and services that states are not required to cover.[9] Why are states reluctant to cut benefits?

- **Citizens value Medicaid benefits.** Many benefits, such as those for the chronically mentally ill and developmentally disabled, were covered by states before Medicaid came along.[10] Providing health and long-term care coverage for low-income children, the disabled, and elderly has proven politically popular.[11]
- **Some benefits may strengthen families and improve human capital.** According to recent research, good health could increase annual earnings by about 15% to 20% as a result of increased labor force participation and work effort. When people earn more, they pay more taxes and reduce government costs for disability and other health programs.[12] On the other hand, poor health has been linked to lower labor force participation, lower work productivity, and reduced earnings. Children in poor health are more apt to be absent from school, have lower school achievement, and have poorer cognitive skills.[13]
- **Some benefits can save money, so cuts would be penny wise and pound foolish.** Some benefits such as prescription drugs and physical therapy can substitute for or reduce the costs of more expensive benefits like hospital stays, nursing home care, or physician services.[14] Chiropractic services and podiatry are less costly than orthopedics, just as optometrists are cheaper than ophthalmologists.
- **Some cuts don't save states much money.** Reducing Medicaid expenditures is not a dollar-for-dollar savings. When states make cuts, they lose federal matching funds. In Wisconsin, the federal matching rate has averaged 58% recently, so cutting a dollar in expenditures saves only 42 cents. What's more, cutting optional acute care benefits saves little money and the benefits are often of great importance to certain participants and providers.[15]
- **Provider groups are politically powerful.** The ability to cut payments to provider groups is hampered by the political power of these groups.[16]

Who is Covered by Medicaid?

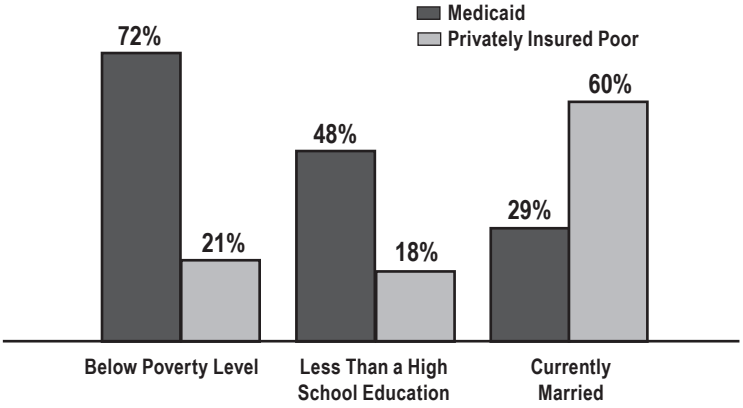
Nationally, Medicaid serves 40 million low-income Americans and in Wisconsin, it served about 807,000 low-income residents or 15% of Wisconsin's population sometime in Fiscal Year 2004. To better understand who benefits, Medicaid enrollees were compared to the low-income poor—those under 200% of the Federal Poverty Level—who were covered by private health insurance.

Medicaid served about 15% of Wisconsin's population sometime in FY 2004.

When compared to low-income people who are privately insured, the Medicaid population is much poorer, has less education, and is less likely to be married (See Figure 2).

Medicaid families are poorer, less educated, and less likely to be married than the privately insured poor.

Figure 2: Medicaid Families are Poorer, Less Educated, and Less Likely to be Married

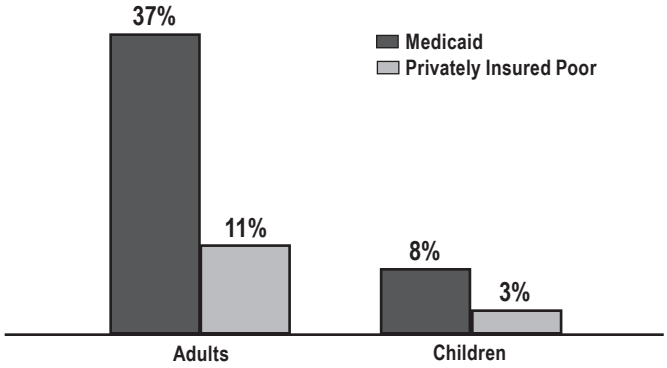


Note: All differences are significant at the .05 level. This chart compares families with income below 200% of the Federal Poverty Level that were covered by Medicaid or private insurance between 1996 and 1999.

Nationally, the family income of a Medicaid family is $18,644 compared to $32,677 for a low-income family covered with private insurance. Not surprisingly, those on Medicaid were about 5 times more likely to be living under the poverty level. About 72% of those on Medicaid had family incomes below the poverty level compared to only 21% of low-income families with private health coverage.[17]

Of the Medicaid population, almost half (48%) had less than a high school education compared to about a fifth (18%) of their low-income counterparts with private insurance. Those with private insurance were twice as likely to be married as those on Medicaid (60% compared to 29%).[18]

Figure 3: Medicaid Recipients are More Likely to be in Fair or Poor Health



Note: All differences are statistically significant at the .05 level. Low income defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.

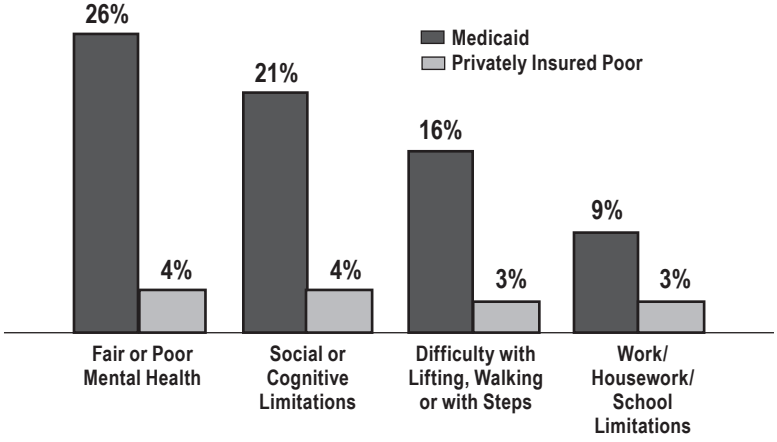
The Medicaid population is more apt to be sick or in poor health. As shown in Figure 3, the differences are quite striking, with over a third of Medicaid enrollees (37%) reporting fair or poor health, compared to only about 1 in 10 (11%) of the poor with private insurance. Conversely, 59% of those with private coverage reported being in excellent or good health, compared to only 34% of those with Medicaid coverage.[19]

The Medicaid population is more apt to be sick or in poor health than the privately insured poor.

The health differences were less pronounced in children. Of the Medicaid children, 8% were in fair or poor health compared to 3% for poor children receiving private coverage.

Cognitive and physical limitations are high among the poor with Medicaid coverage (see Figure 4). When compared to the poor who are privately insured, the Medicaid population is more apt to be in fair or poor mental health; have difficulty lifting, walking, or with steps; and have trouble with work, housework, and school. When given a list of 9 limitations, Medicaid enrollees were almost four times more likely to report one of these limitations (43%) compared to the privately insured poor (11%). Moreover, they are more likely to have died or been institutionalized during the year.

Figure 4: Medicaid Adults are More Apt to Have Physical and Cognitive Limitations



Note: All differences are significant at the .05 level. This chart compares families with income below 200% of the Federal Poverty Level that were covered by Medicaid or private insurance between 1996 and 1999.

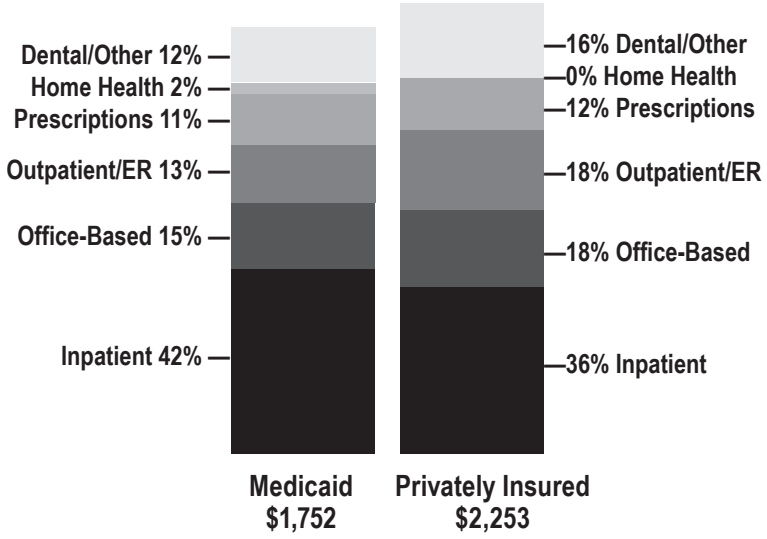
For children, almost 19% of those on Medicaid reported having some type of limitation, compared to 13% of low-income children receiving private coverage. Children with Medicaid coverage are more likely to have asthma and less likely to have infectious diseases than privately insured low-income children.[20]

Is Medicaid a Cadillac Program?

Because of its long list of benefits, Medicaid has been called a "Cadillac" program.[21] Are overly generous benefits contributing to Medicaid costs?

The services provided by the Medicaid benefit package that are often considered too generous are dental and other services which states are not required to cover under federal law. As shown in Figure 5, the services thought of as "Cadillac" benefits account for 12% of expenditures in the Medicaid insured group. In fact, per person expenditures for these services were actually higher for the poor covered under private insurance than for those covered under Medicaid. Most of the expenditures for services in both groups are for inpatient care, office services, outpatient and emergency department care, and prescription drugs.

Figure 5: Benefits Considered "Overly Generous" Account for 12% of Medicaid Spending



Note: This chart compares all low income non-disabled adults (excluding those with fair or poor mental health or any physical limitations). Low income is defined as below 200% of the Federal Poverty Level.

The privately insured pay annual out of pocket costs that are twice those of Medicaid ($585 versus $266). When disabled adults were excluded from all analyses, the privately insured paid six times more than those on Medicaid ($508 compared to $91). Given that Medicaid recipients are sicker and poorer, however, it is not clear how much out-of-pocket spending they can afford or should be expected to pay.[22]

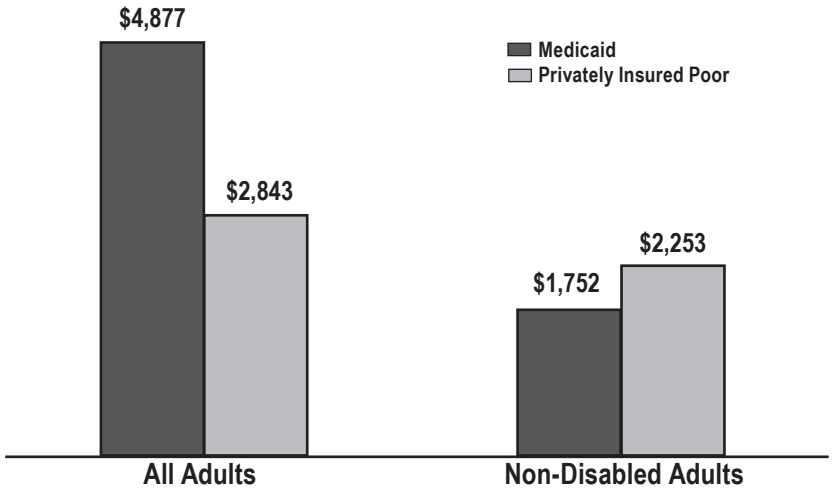
Spending for non-disabled Medicaid adults is less than for non-disabled poor adults covered by private insurance.

How Cost Effective is Medicaid?

Per person expenditures for adults covered by Medicaid are higher than for the privately insured poor. As shown in the left side of Figure 6, Medicaid costs $4,877 per person compared to $2,843 for the privately insured poor.

However, when adults with fair or poor mental health or any physical limitations were excluded from all analyses, Medicaid spending dropped by about two-thirds to $1,752 per person. Thus, spending for non-disabled Medicaid adults is significantly lower than for their non-disabled counterparts who are privately insured ($2,253).

Figure 6: Medicaid Spending is Higher When All Adults are Included, But Lower When Excluding People with Disabilities/Limitations



Note: All differences are statistically significant at the .05 level. This chart compares all adults and non-disabled adults (excluding those with fair or poor mental health or any physical limitations).

Among poor children, Medicaid was less expensive than private coverage for all children and for non-disabled children; however, these differences did not meet conventional standards of statistical significance and may be due to chance.

This suggests that the higher spending for Medicaid when all adults are included is due, in part, to the much poorer health of the Medicaid population. No evidence emerges that Medicaid's lower costs were due to lower use of services such as office visits, doctor visits, and hospital stays. However, the lower cost for the non-disabled Medicaid population is probably due, in part, to Medicaid's lower provider payment rates. Also, Medicaid enrollees may have less access to specialists and technology/intensive care for those in fair or poor health.[23]

Taken together, if those with Medicaid were given private coverage, they would cost considerably more than they do today under Medicaid. If those with private coverage were covered under Medicaid, spending would be lower; however, these savings are not as striking because those covered under private coverage are generally healthier.

Optional benefits add about 12% to total Medicaid expenditures.

What Questions Can Policymakers Ask to Guide Difficult Medicaid Budget Decisions?

State policymakers are faced with a thorny problem. Even though Medicaid appears to be a cost-effective approach for providing health coverage to the poor, the costs are high in an absolute sense and are growing faster than state revenues. Given that most of the optional benefits add only about 12% to total costs, state policymakers face some tough decisions that may have consequences for many years to come.

Clearly, there are no easy textbook answers. The following questions may raise some of the considerations that policymakers may want to take into account as they make these difficult decisions.

Will healthy parents do a better job of raising their children into competent, caring adults?

- What effects will proposed changes in benefits or eligibility have on the health of Medicaid enrollees? Will those in better health work more and earn higher incomes?[24]
- How do Medicaid programs affect the health of children and their future potential to become productive workers? Will healthy parents do a better job of raising their children into competent and caring adults? (For a complete list of family impact questions, see the Checklist for Assessing the Impact of Policies on Families in this report.)
- Will cuts in Medicaid cause the number of uninsured people to rise?[25]
- Is providing care to the uninsured, who often can't pay for services, really free care? Who ends up picking up the costs—providers, cities, counties, states?
- Will cuts in provider rates affect beneficiaries' access to care?[26]
- Will rate cutbacks and eligibility restrictions threaten the financial viability of institutions, such as safety net hospitals?[27]

John Holahan is the Director of the Health Policy Research Center at the Urban Institute in Washington, DC. Dr. Holahan has written 10 books, 90 papers, 30 briefs, and 24 monographs on topics such as Medicaid and other state health policy issues. These include analyses of the recent growth in Medicaid expenditures, variations in expenditures across states, and the effects of proposals to expand health insurance on the number of uninsured and the cost to federal and state governments. He has spoken at seven state legislatures across the country and is a frequent speaker at meetings of the National Conference of State Legislatures.

References

[1, 11, 15, 26, 27] Holahan, J., Coughlin, T. A., Bovbjerg, R. R., Hill, I., Ormond, B. A., & Zuckerman, S. (2004, February). *State responses to 2004 budget crises: A look at ten states.* Washington, DC: The Urban Institute. Retrieved August 31, 2005 from http://www.urban.org/UploadedPDF/410946_StateBudgetCrises.pdf.

[2, 4, 6, 8, 25] Holahan, J., & Ghosh, A. (2005, January 26). Understanding the recent growth in Medicaid spending, 2000-2003. *Health Affairs Web Exclusive*, W5, 52-62.

[3, 10, 14, 16] Holahan, J., & Weil, A. (2003, June 18). *Medicaid moving in the wrong direction?* (commentary). Washington DC: The Urban Institute. Retrieved August 30, 2005 from http://www.urban.org/url.cfm?ID=900638.

[5] Holahan, J., & Wang, M. (2004, January 28). Changes in health insurance coverage during the economic downturn: 2000-2002. *Health Affairs Web Exclusive,* W4, 31-42.

[7] Wisconsin Department of Health and Family Services. (2004, September). *Wisconsin Insurance Coverage 2003 (*PPH5369-03). Madison, WI: Division of Public Health, Bureau of Health Information and Policy.

[9] Kaiser Commission on Medicaid and the Uninsured. (2005, June). *Medicaid: An overview of spending on "mandatory" vs. "optional" populations and services.* Washington, DC: Author. Retrieved September 12, 2005 from http://www.kff.org/medicaid/7331.cfm.

[12, 13, 24] Hadley, J. (2003, May). Sicker and poorer: The consequences of being uninsured. *Medical Care Research and Review,* 60(2), 3-75. Available online at: http://www.kff.org/uninsured/20020510-index.cfm

[17-23] Hadley, J., & Holahan, J. (2003, February 12). How much medical care do the uninsured use, and who pays for it? *Health Affairs Web Exclusive,* W3, 66-81.