fiscal forum

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HOUSE FISCAL AGENCY

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MEDICAID'S IMPACT ON THE STATE BUDGET

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Medicaid expenditures are escalating at a rate that exceeds Michigan's projected General Fund/General Purpose (GF/GP) revenue growth. Unless significant change occurs, an ever-increasing share of state revenues will need to be devoted to Medicaid (Figures 1 and 2).

Michigan's General Fund/General Purpose structural deficit cannot be remedied without addressing the issue of Medicaid.

Medicaid is the state's primary health care safety net program. It provides coverage to more than 1.35 million low-income and uninsured persons in Michigan. The program serves low-income pregnant women, children, families, persons with disabilities, and the elderly who meet the program's financial eligibility requirements.

During the recent economic downturn, Michigan has relied on a variety of cost containment actions, fund shifts, one-time revenues (including over $400 million from the Medicaid Benefits Trust Fund), and special financing payments to fund the Medicaid program. Current Medicaid eligibility, services, and provider reimbursement levels cannot be maintained in FY 2004-05 without a minimum of $500 million in additional revenue and/or cost savings measures.

- **$152.0 million** needed to cover a projected 5% growth due to Medicaid caseload, utilization, and inflation increases (actual growth may exceed 5%)

- **$120.0 million** needed to cover reductions in one-time revenues, unrealized cost savings, and a potential 10–15 % increase

Almost 1/4
of Michigan's GF/GP revenue is appropriated for Medicaid

1 of 8
Michigan residents eligible for Medicaid in December 2003

Over 1/3
of births and
70%
of nursing home expenditures in Michigan financed through Medicaid

Over $7.1 billion
total appropriated for Medicaid services in FY 2003-04

40.2%
increase in Medicaid funding since FY 1999-2000

27.4%
Medicaid caseload growth (290,000 cases) since FY 1999-2000

in Medicaid HMO capitation payment rates to meet federal actuarial soundness requirements

- **$130.0 million** needed to cover the continuing loss of Medicaid special financing revenues

  For the past decade, Michigan has relied on a variety of Medicaid special financing strategies to maximize federal funding and replace state GF/GP that otherwise would be have been needed to fund the Medicaid program. These measures have saved the state over $500 million per year in GF/GP costs. However, federal rule changes adopted several years ago began phasing out a major portion of the special financing payments, and this phase-out will reduce revenues used to fund Medicaid by approximately $130 million in FY 2004-05.

- **$168.4 million** needed to cover the loss of temporary federal fiscal relief received in FY 2003-04 that will be partially offset by $72.7 million in savings from an increase in the regular Medicaid match rate

Why are Medicaid costs increasing so rapidly?

Medicaid expenditures have soared in recent years primarily due rapid growth in the number of persons eligible for the program, increased utilization of services, inflation in service costs and higher medical provider payments. Eligibility expansions over the past decade and higher unemployment levels have contributed to the growing Medicaid caseload and program costs (Figure 3).

The rapid introduction of new health care technologies, costly new prescription drugs, and the greater need for medical services as the population ages have also contributed to the increased utilization of Medicaid services and added expenditures.

An increase of 10,000 Medicaid-eligible persons generally translates into an estimated $25 million in additional Medicaid costs annually.

What can be done to reduce the cost of Medicaid?

In general, options available to reduce the cost of Medicaid can be grouped into several categories:

- Tighten eligibility requirements to limit the number of people who qualify for Medicaid

- Reduce the level of services provided by eliminating benefits and/or increasing patient co-payments

- Lower reimbursement levels to medical providers

It is important to note, however, that these options could increase the number of uninsured, reduce access to services, and increase the uncompensated care burden on hospitals and other medical providers.

In some instances, reductions to Medicaid services may also jeopardize the health status of the affected populations, increase the need for more expensive care, reduce the number of medical providers who are willing to treat Medicaid patients, and threaten the financial viability of hospitals, nursing homes, HMOs, and other medical providers.

What has Michigan done so far to reduce Medicaid costs?

Michigan has actively attempted to slow the rate of growth of Medicaid associated costs. Recent actions the state has taken to better control Medicaid expenditures include the following:

- Freezing and lowering health care provider payment rates

- Limiting enrollment in the home- and community-based services program

- Eliminating non-emergency adult dental benefits, chiropractic services, podiatric services, and hearing aid services for adults

Figure 1

Total FY 2003-04 Year-to-Date GF/GP Appropriations = $8,812.9 million

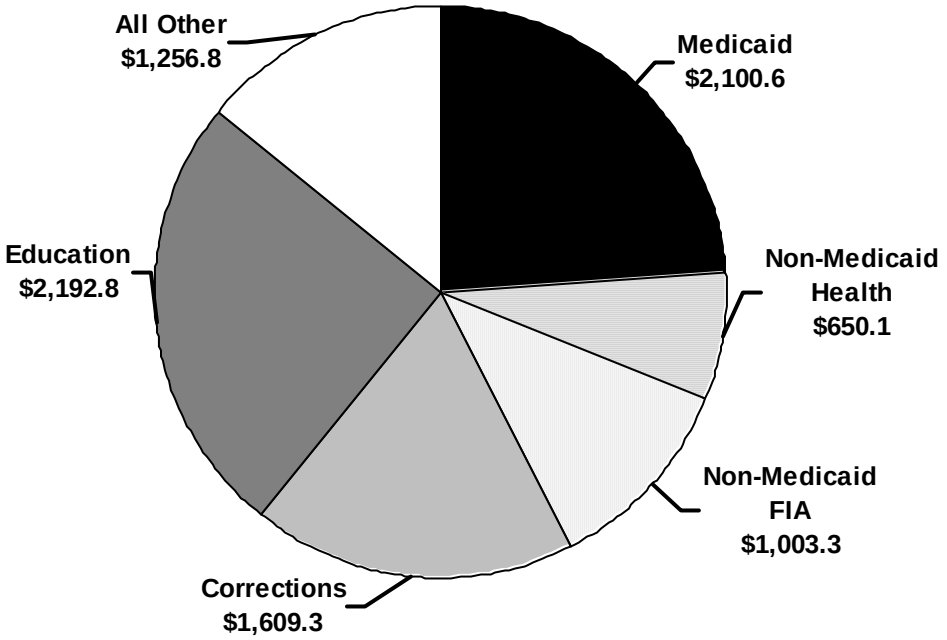
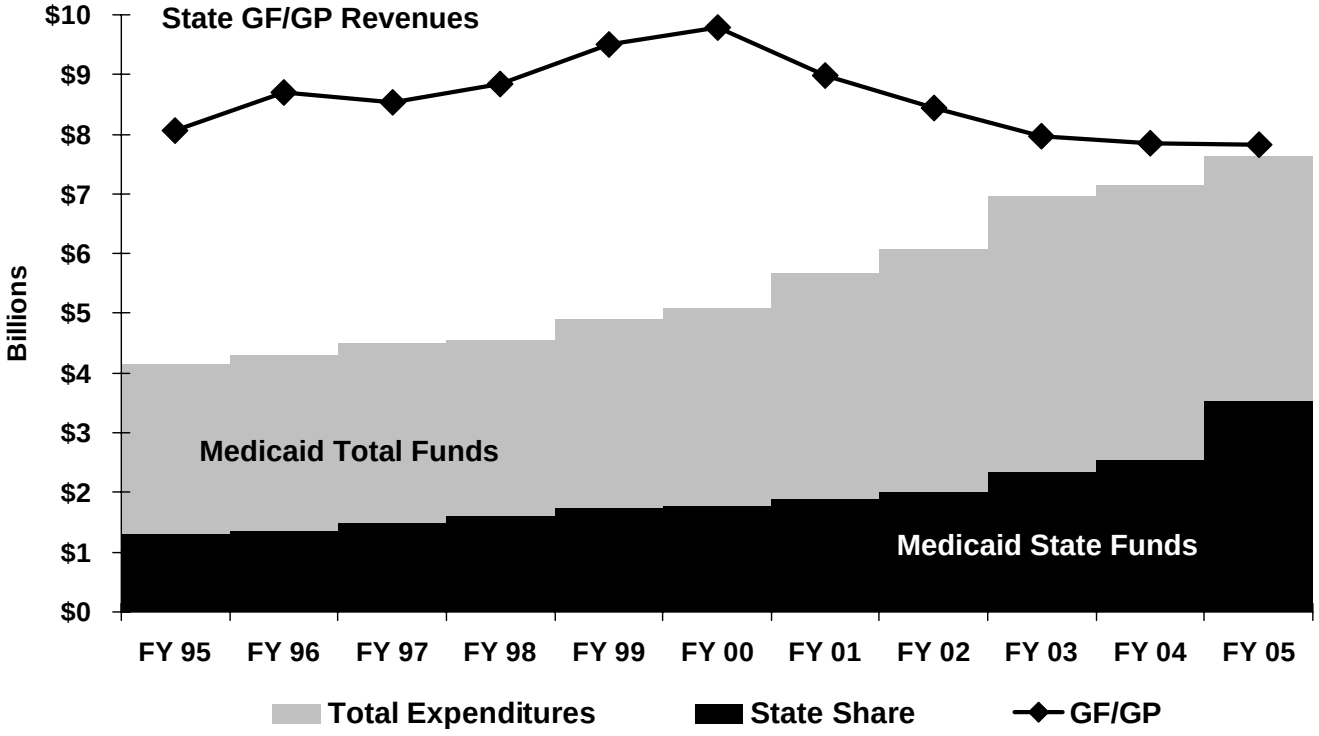


Figure 2

State GF/GP Revenues and Medicaid Costs

The cost of Medicaid services has increased steadily since FY 1994-95; state GF/GP revenues peaked in FY 1999-00 and have since fallen sharply.

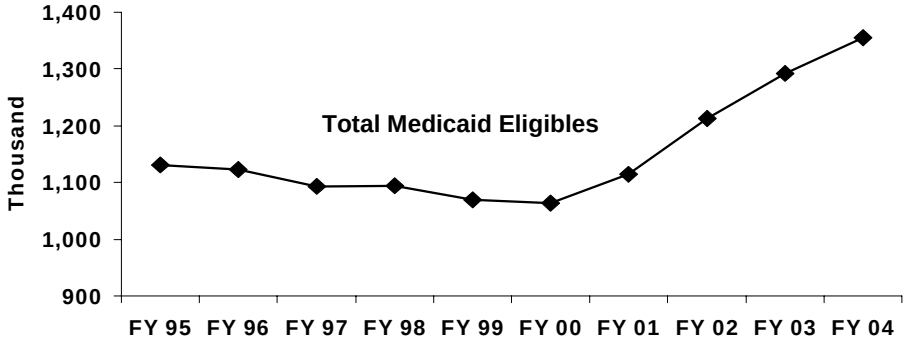


**FY 04 = Year-to-Date appropriation; FY 05 = House Fiscal Agency estimate*

Figure 3

Medicaid Caseload

The number of persons eligible for Medicaid has risen by over 290,000, or 27.4%, since FY 1999-2000, after five years of gradual decline



Note: FY 04 = December Caseload

Figure 4

Medicaid Eligibles

73% of Medicaid eligibles are pregnant women, children, and families; elderly and disabled persons make up the remaining 27%

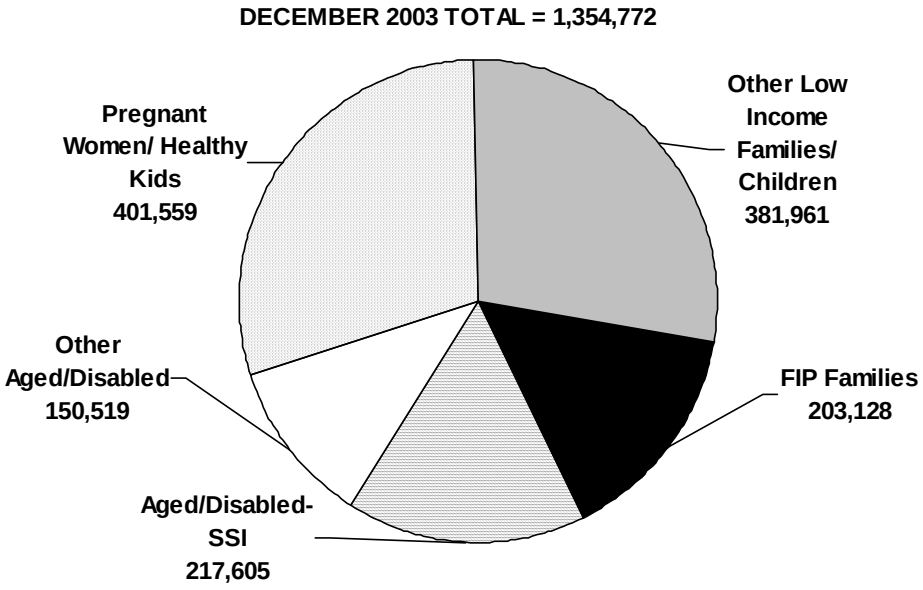
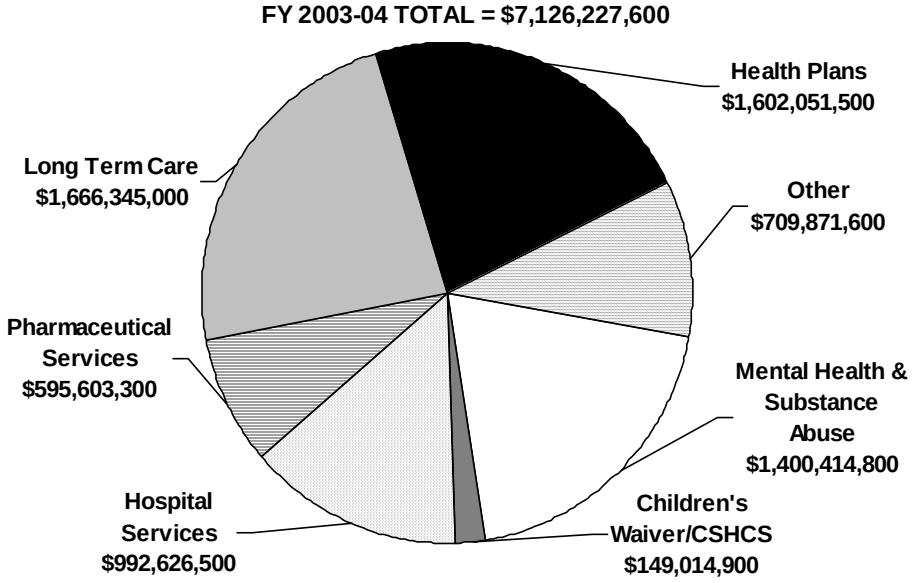


Figure 5

Medicaid Services Funding

88% of Medicaid services costs are for long term care, health plan services, mental health and substance abuse, hospital care, and pharmaceutical services



- Seeking federal approval to limit services provided and require higher co-payments for adult Medicaid recipients

- Implementing a preferred drug list, seeking supplemental rebates, lowering the price paid for generic drugs, and joining with other states to obtain greater discounts from drug manufacturers

- Reducing Medicaid graduate medical education payments to teaching hospitals

- Establishing provider taxes to finance Medicaid payment rate increases and reduce state GF/GP costs

Other cost-saving measures that were approved as part of the FY 2003-04 Community Health budget include reducing adult home help program costs, adopting a new screening/assessment process for long-term care admissions, and developing an estate recovery program.

What are Medicaid mandated and optional populations?

Federal requirements limit the state's ability to control Medicaid costs by mandating coverage for certain populations and services in order to receive federal matching funds. Mandatory Medicaid eligibility groups include the following:

- Low-income families who qualify for the Family Independence Program (FIP); aged, blind, and disabled persons on SSI

- Pregnant women and children under age six up to 133% of the poverty level (see Table below)

- Children age six or older up to 100% of the poverty level

Federal Poverty Income Guidelines for 2004
(FIA Projection)

Family Size	100%	133%	150%	185%
1	$9,250	$12,303	$13,875	$17,113
3	$15,650	$20,815	$23,475	$28,953

In addition to covering federally-mandated populations, Michigan extends coverage to certain optional populations, including:

- Parents and caretaker relatives of Medicaid-eligible children with income above cash assistance levels

- Aged, blind, and disabled persons up to 100% of poverty who do not qualify for SSI

- Pregnant women and newborn children between 133% and 185% of poverty

- Older children up to 150% of poverty

The majority of Medicaid recipients in Michigan are included in the federally-mandated categories, but precise numbers on the associated costs are not available for all eligibility groups (Figure 4).

It is important to note that the vast majority of total Medicaid costs are related to serving the elderly and disabled population groups who have greater health care needs than other Medicaid beneficiaries. Aged, blind, and disabled persons represent approximately 27% of the Medicaid-eligible population, but they account for about 70% of all Medicaid expenditures.

Elimination of coverage for caretaker relatives was proposed last year, but a court order prevented implementation because the coverage elimination was attempted through an Executive Order reduction. It was anticipated that the change would terminate eligibility for almost 40,000 adults and reduce annual Medicaid GF/GP costs by approximately $55 million. Because many of the affected individuals may have retained coverage under other Medicaid eligibility categories, the actual savings would have been lower.

As an optional coverage, limited Medicaid benefits for indigent single adults and childless couples are being financed under the newly-approved adult benefits waiver program. This population is currently served through the state medical program and county-based indigent care plans. More federal matching funds will be available under the new waiver program.

What are Medicaid mandated and optional services?

The federal government requires that certain services be provided to Medicaid recipients, including:

- Hospital, physician, and nursing home care
- Laboratory and x-ray services
- Family planning
- Medical transportation
- Home health for person over 21
- Health screening, diagnosis, and treatment for children

The majority of Medicaid expenditures are for federally-mandated services.

In addition to federally-mandated services, Michigan also covers certain optional services, including:

- Prescription drugs
- Intermediate care for the mentally retarded
- Home- and community-based services waiver program
- Personal care and adult home help
- Hearing, vision, and speech services
- Podiatric and chiropractic services

Prescription drug coverage is the most utilized and most costly of the optional Medicaid benefits noted above, with annual fee-for-service costs of over $600 million. Over 20% of health plan expenditures are also for pharmacy services (Figure 5).

Adult dental, podiatric, chiropractic, and hearing services to adults were eliminated effective October 1, 2003.

What is the impact of Medicare prescription drug coverage on future state Medicaid costs?

A significant portion of Michigan's Medicaid costs are attributable to providing long-term care and prescription drug benefits to low-income elderly and disabled persons on Medicare who also qualify for Medicaid. An estimated 190,000 Michigan residents are "dually eligible" for both Medicare and Medicaid.

According to recent estimates, total Medicaid spending on this dually eligible population was nearly $1.9 billion in 2002. Two-thirds of this amount (over $1.2 billion) is related to long-term care costs and 19% ($358 million) is for prescribed drugs. In contrast, the federal Medicare program will only pay for nursing home care in very limited situations, and it currently does not cover prescribed drugs provided on an outpatient basis.

Under the newly-enacted Medicare drug benefit, Michigan will be required to pay 90% of the state costs for Medicaid-Medicare dual eligibles in 2006. The state's share will gradually decline to 75% in 2015. While this will result in savings to Michigan in future years, it may not be enough to offset the increases in drug prices and utilization that drive up pharmaceutical costs.

Whether the state or federal government should have primary responsibility for financing the cost of long-term care and prescription drugs for the Medicare population is a longstanding debate. If the federal government were to pay 100% of long-term care and prescription drugs costs for those dually eligible for Medicaid and Medicare, it is estimated that the state would save approximately $700 million GF/GP this year, and even more in the future. It would also go a long way toward solving the long-range funding problems facing Michigan's Medicaid program.

Summary

The projected Medicaid shortfall for FY 2004-05 is $500 million—one-half of the total estimated GF/GP budget shortfall. Permanent reductions in spending for Medicaid, increases in funding, or some combination of the two, may be required to produce a balanced state budget for FY 2004-05 and address Michigan's long-term structural deficit.