

# **CBO TESTIMONY**

Statement of  
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on  
The Status of the Medicaid Program

before the  
Subcommittee on Health and Environment  
Committee on Commerce  
U.S. House of Representatives

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## **NOTICE**

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Wednesday, June 21, 1995.



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Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here today to discuss the status of the Medicaid program. The rapid increases in Medicaid spending and the growing prominence of the program in the federal budget present a serious challenge to the Congress.

Between 1988 and 1993, overall Medicaid spending increased at an annual rate of 16 percent, while the federal share increased at the remarkable rate of 20 percent per year. Yet over the same period national health expenditures rose by less than 10 percent a year. Under current law, Medicaid expenditures are expected to continue to rise faster than other health expenditures. With federal spending of \$89 billion in 1995, Medicaid now accounts for about 6 percent of the federal budget. By 2002, that share is projected to increase to 8 percent, or about \$178 billion.

Both the House and Senate versions of the budget resolution for 1996 assume significant reductions in the rate of growth of Medicaid spending. Under the assumptions of the budget resolutions passed by the House and Senate, federal Medicaid spending in 2002 would be only \$121 billion or \$125 billion, respectively. Those amounts are well below CBO's current projection of federal Medicaid spending in that year. Clearly, reducing the growth in program spending will require both the Congress and the states to make significant policy changes.



My statement today addresses four topics:

- o An overview of the Medicaid program,
- o Past trends in program spending,
- o CBO's projection of future spending under current law, and
- o Considerations in modifying the Medicaid program to meet the requirements of the budget resolution.

## OVERVIEW

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Medicaid is the nation's major program providing medical and long-term care services to low-income populations. The federal and state governments jointly fund the program. The states administer it, however, and though they are subject to federal guidelines, they retain considerable discretion over all aspects of program operation. The federal share of total Medicaid spending in a state varies inversely with the per capita income of the state, subject to a lower limit of 50 percent and an upper limit of 83 percent.



## Medicaid Beneficiaries

The Medicaid program has always covered most recipients and potential recipients of cash welfare benefits provided through the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income programs. In addition, coverage has been extended to large numbers of poor and near-poor children and pregnant women, as well as to certain low-income Medicare beneficiaries. In 1993, more than 33 million people received Medicaid benefits. Children under the age of 21 are by far the largest group of Medicaid beneficiaries, accounting for almost half of the total in 1993. About 12 percent of beneficiaries were elderly and 15 percent disabled. Most of the remainder were nondisabled adults.

The majority of Medicaid beneficiaries are poor or near-poor. In 1992, according to the Census Bureau's Current Population Survey, 61 percent of the noninstitutionalized Medicaid population was in families with income below the poverty level and 74 percent was in families with income below 133 percent of the poverty level.

## Provision of Services

Medicaid covers both acute medical services and long-term care. The federal government requires all states to provide a core group of services, including hospital,



physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the states do so. Optional services include drugs, dental services, eyeglasses, and personal care services. The typical Medicaid beneficiary receives acute care services free of charge or for a nominal copayment. However, beneficiaries often face limited access to providers, many of whom are unwilling to see Medicaid patients.

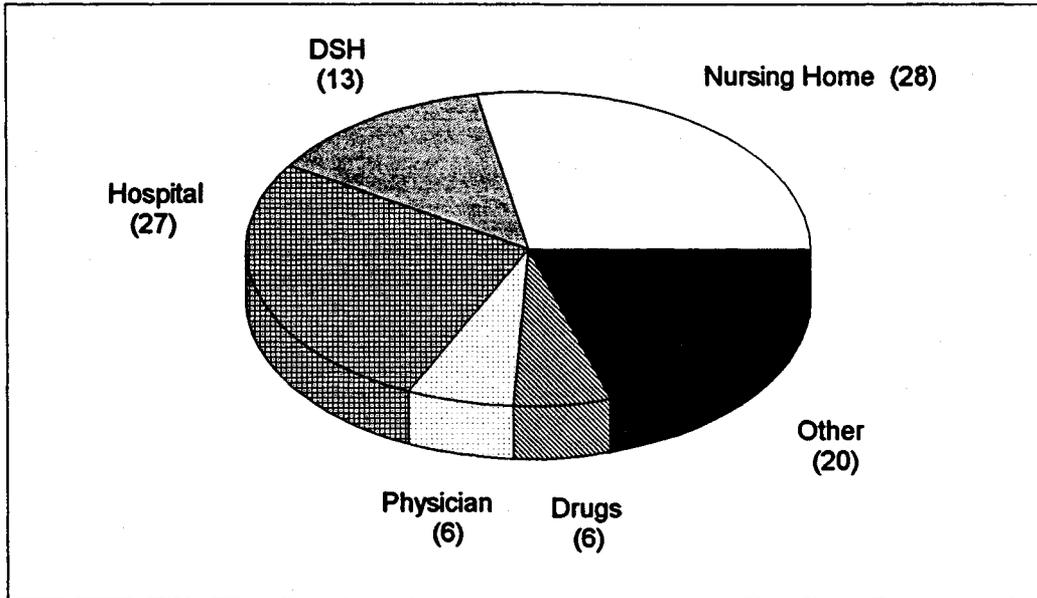
Concern about access to providers was an important factor in the decision of some states to develop managed care arrangements for providing acute care services to some of their Medicaid beneficiaries--generally nondisabled adults and children. By June 1994, about 8 million Medicaid beneficiaries--almost a quarter of the total--were enrolled in managed care plans in 42 states and the District of Columbia.

#### Expenditures by Type of Service

The largest share of Medicaid expenditures is for hospital and nursing home services, which accounted for more than half of the total in 1993 (see Figure 1). Hospital expenditures include payments to hospitals for inpatient and outpatient services received by Medicaid beneficiaries. In addition, disproportionate share hospital (DSH) payments are made to hospitals that serve disproportionately large numbers



**FIGURE 1. DISTRIBUTION OF MEDICAID EXPENDITURES  
BY CATEGORY OF SERVICE, FISCAL YEAR 1993  
(In percent)**



**SOURCE:** Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-64.

**NOTES:** Nursing home expenditures include spending for nursing home facilities and intermediate care facilities for the mentally retarded.

Hospital expenditures include spending for inpatient and outpatient care.

DSH = disproportionate share hospital payments.



of Medicaid and uninsured patients. Nursing homes include general nursing facilities as well as intermediate care facilities for the mentally retarded.

### Expenditures by Eligibility Status

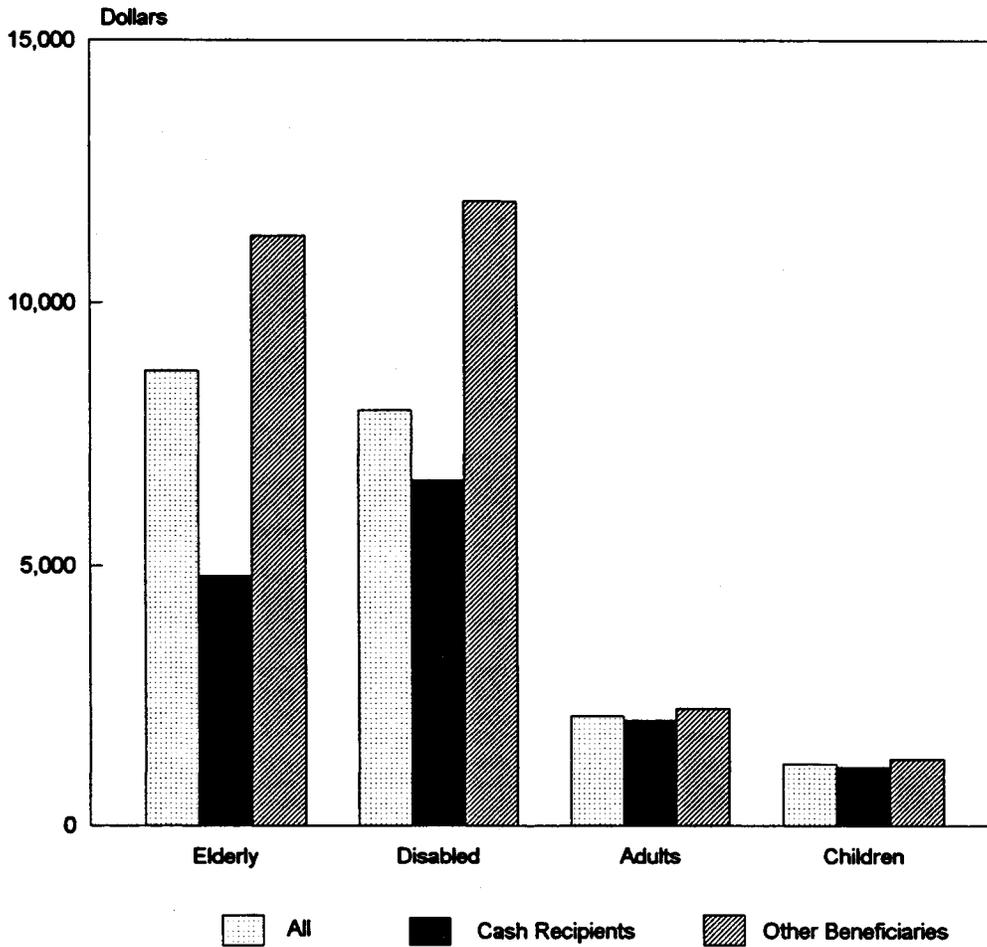
Because of their use of nursing home services and their extensive acute care needs, elderly and disabled Medicaid beneficiaries generate much higher medical expenditures than do children and other adults (see Figure 2). Some elderly and disabled beneficiaries become eligible for Medicaid because of their need for costly nursing home services, even though they have not received cash welfare benefits. As a result, although the elderly and disabled represented less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of all Medicaid expenditures, excluding DSH payments (see Figure 3).

### Variation in State Expenditures

Both the levels of and recent trends in Medicaid expenditures vary considerably from state to state (see the appendix). A number of reasons account for that variation: the size and makeup of the beneficiary population, the coverage of optional services, the use of services by beneficiaries, payment levels for providers, differences in



**FIGURE 2. MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993**

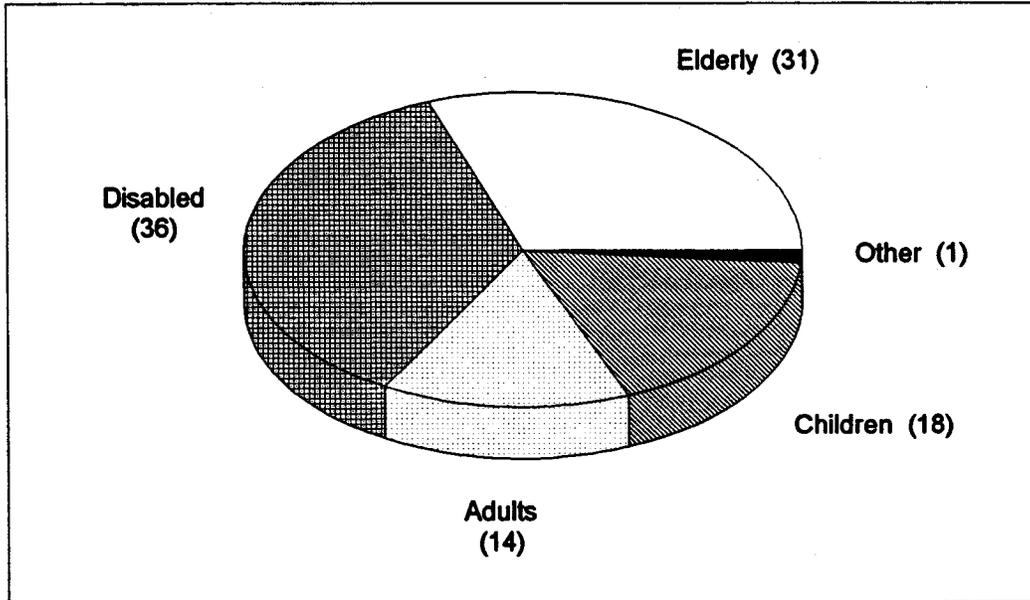


**SOURCE:** Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

**NOTE:** Excludes administrative costs and disproportionate share payments.



**FIGURE 3. DISTRIBUTION OF MEDICAID EXPENDITURES  
BY ELIGIBILITY GROUP, FISCAL YEAR 1993  
(In percent)**



**SOURCE:** Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

**NOTE:** Excludes administrative costs and disproportionate share payments.



underlying health care costs, and variations in federal matching rates. In addition, some states have raised DSH payments substantially by taking advantage of certain financing schemes, whereas others have not.

Because of those factors, total Medicaid expenditures vary much more widely among the states than one might expect, given the relative size of their low-income populations. In California, for example, about 5.8 million people were in families with income below the poverty level in 1993 compared with about 3 million in New York. But in 1993, New York spent \$18 billion on Medicaid (excluding administrative costs), whereas California spent only \$14 billion. Medicaid expenditures (excluding DSH payments) per enrollee also vary widely among the states, ranging from less than \$2,000 in Alabama, California, and Mississippi in 1993 to more than \$5,000 in New York.<sup>1</sup>

## TRENDS IN SPENDING

Since 1975, Medicaid expenditures have grown at an uneven rate, and recent patterns of growth have not reflected those of Medicare, private health insurance, or national

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1. Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).



health expenditures (see Table 1).<sup>2</sup> For analytic purposes, the trend in Medicaid expenditures for the 1975-1993 period can be divided into three distinct periods: 1975 to 1981, when Medicaid spending grew rapidly but still remained at virtually the same rate as national health expenditures; 1981 to 1988, when Medicaid spending grew relatively slowly and somewhat less rapidly than national health expenditures; and 1988 to 1993, when Medicaid spending grew extremely rapidly and much faster than national health expenditures.

Between 1975 and 1981, Medicaid spending grew at about 14 percent a year, the same as national health expenditures. Private health insurance and Medicare expenditures both grew at about 18 percent a year during that same period. Since the number of beneficiaries remained virtually unchanged at around 22 million, the growth in Medicaid spending was attributable to increases in prices and utilization per beneficiary.

Medicaid expenditures grew relatively slowly during the 1981-1988 period, at an annual rate of about 9 percent. Medicare and private health insurance spending grew at 10 percent and 12 percent, respectively, and national health expenditures grew at about 10 percent. As in the previous period, the growth in Medicaid

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2. CBO's analysis of spending trends is based on data from the national health accounts. In developing those estimates, the Health Care Financing Administration reduced the amount of disproportionate share payments to hospitals when such payments were offset by taxes and donations paid by the same facilities. The effect is to reduce the estimates of state Medicaid spending in the 1990s below the levels actually reported by the states. See Katherine R. Levit and others, "National Health Spending Trends, 1960-1993," *Health Affairs*, vol. 13 (Winter 1994), pp. 14-31.



**TABLE 1. NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 1975-1993 (By calendar year)**

Source of Payment	1975	1980	1985	1990	1993
<b>Billions of Dollars</b>					
National Health Expenditures	132.6	251.1	434.5	696.6	884.2
Private Health Insurance	32.0	72.1	139.8	236.9	296.1
Medicare	16.4	37.5	72.2	112.1	154.2
Medicaid	13.5	26.1	41.3	75.4	117.9
Federal	7.4	14.5	22.8	42.7	76.1
State and local	6.1	11.6	18.4	32.7	41.8
Other	70.7	115.3	181.2	272.1	316.0
<b>Average Annual Growth Rate from Previous Year Shown (Percent)</b>					
National Health Expenditures	n.a.	13.6	11.6	9.9	8.3
Private Health Insurance	n.a.	17.6	14.2	11.1	7.7
Medicare	n.a.	18.0	14.0	9.2	11.2
Medicaid	n.a.	14.1	9.6	12.8	16.0
Federal	n.a.	14.3	9.5	13.3	21.2
State and local	n.a.	13.9	9.7	12.2	8.5
Other	n.a.	10.3	9.5	8.5	5.1
<b>Average Annual Growth Rate over Indicated Periods (Percent)</b>					
		<u>1975-1981</u>	<u>1981-1988</u>	<u>1988-1993</u>	
National Health Expenditures		14.0	9.8	9.5	
Private Health Insurance		17.7	11.7	9.9	
Medicare		18.3	10.3	11.5	
Medicaid		14.5	8.9	16.4	
Federal		15.0	8.8	19.6	
State and local		13.8	9.0	11.7	
Other		10.8	8.6	6.3	

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of National Health Statistics.

NOTE: n.a. = not applicable.



expenditures primarily reflected price increases and increases in utilization per beneficiary; the number of beneficiaries grew only slightly during the period, reaching about 23 million in 1988. Indeed, in spite of the effects of the 1981-1982 recession, the number of Medicaid beneficiaries actually fell slightly between 1981 and 1983. Several factors contributed to that decline, particularly cutbacks in the AFDC program combined with new Medicaid options that granted states greater flexibility in determining which groups of children to cover. Although the Congress authorized expanding eligibility for children and pregnant women beginning in 1984, the early expansions were tied to categorical eligibility for welfare and did not have a major impact on the number of beneficiaries.

The 1988-1993 trends represented a break with past patterns. Previously, the growth in Medicaid spending had trailed behind that of private health insurance and Medicare. During the 1988-1993 period, however, Medicaid expenditures soared, rising at an average annual rate of about 16 percent, although national health expenditures grew at less than 10 percent. Private health insurance expenditures grew at about 10 percent during the period, and Medicare spending grew at less than 12 percent. The most striking increases occurred between 1990 and 1992, when Medicaid spending jumped by over 40 percent. Several factors contributed to Medicaid's dramatic growth: sharp rises in Medicaid enrollment, increased payments to providers, and financing schemes and disproportionate share payments.



## Rapid Increases in Medicaid Enrollment

In contrast to earlier periods, 1988 to 1993 was marked by swift growth in the number of Medicaid beneficiaries. Not only did the number of children covered by the program increase sharply, but enrollment of population groups that are more costly to serve also grew rapidly.

Expansions in Eligibility. Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility. Low-income children and pregnant women were the primary focus of those expansions, but the target populations also included the elderly and the disabled.

Of particular importance were the options granted to the states in the Omnibus Budget Reconciliation Act of 1986, which severed the required link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering low-income children and pregnant women followed, as well as requirements for covering low-income Medicare beneficiaries. The most recent mandatory expansion of the program, authorized in the Omnibus Budget Reconciliation Act of 1990, requires states to provide coverage to all poor children under 19 who were born after September 30, 1983. That requirement means that



mandatory expansions in Medicaid eligibility will continue under current law through 2002.

Such expansions in eligibility, along with efforts to streamline the eligibility process, have brought about large increases in the number of Medicaid beneficiaries who do not receive cash welfare benefits. The number of those beneficiaries rose at an average annual rate of about 17 percent between 1988 and 1993, having risen at an average rate of about 3 percent between 1981 and 1988. By 1993, over 40 percent of Medicaid beneficiaries did not receive cash welfare benefits, compared with less than 30 percent in 1988. Much of that increase, however, was among children, who are the least expensive beneficiaries to cover. The proportion of total expenditures attributable to beneficiaries who do not receive cash benefits increased only slightly over the period.

Although Medicaid expansions increased the number of Medicaid beneficiaries substantially over the late 1980s and 1990s, many of those new beneficiaries might otherwise have been covered by private insurance. A recent academic study found that workers were less likely to participate in employer-sponsored insurance if they had family members who were eligible for Medicaid.<sup>3</sup> The study also found some evidence that when those workers did participate in

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3. David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* Working Paper No. 5082 (Cambridge, Mass: National Bureau of Economic Research, 1995).



employer-sponsored insurance, many opted for individual rather than family coverage.

Effects of the Recession. The 1990-1991 recession sparked greater enrollment in the Medicaid program because more families received cash welfare benefits and fewer families had access to employer-sponsored health insurance. It is not possible, however, to isolate the effects of the recession from other factors affecting enrollment growth.

The number of Medicaid beneficiaries who received cash welfare payments remained virtually constant at about 16.5 million throughout the 1980s. Consistent with the effects of a recession, that number increased to 17.2 million in 1991 and 18.8 million in 1992. But the number continued to rise to 19.6 million in 1993, even when the economy was expanding. Moreover, to some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself spurred growth in welfare caseloads. Some states began conducting aggressive outreach efforts to enroll children and pregnant women in Medicaid in the early 1990s and, in so doing, identified families who were eligible for cash welfare benefits but were not receiving them. The recession also caused other low-income individuals and families to enroll in the Medicaid program, as they lost their jobs or faced reduced hours of work.



Increases in High-Cost Beneficiaries. Medicaid expenditures depend not only on the total number of beneficiaries but also on their distribution among the different categories of eligibility. For a given number of beneficiaries, the higher the proportion of elderly and disabled beneficiaries, the greater spending will be. The proportion of pregnant women among the nondisabled adult population also has an important impact on spending.

The number of disabled Medicaid beneficiaries expanded rapidly in the early 1990s, rising from 3.5 million in 1988 to 5 million in 1993--an increase of 44 percent. Over that period, Medicaid expenditures for the disabled grew from about \$19 billion to about \$40 billion--an increase of over 100 percent. Factors contributing to the growth in the disabled population included expansions in the Supplemental Security Income program for children and increasing numbers of beneficiaries with mental illness. The number of disabled beneficiaries is expected to expand more rapidly than total beneficiaries for the remainder of the decade.

The expansions in eligibility for pregnant women during the 1988-1993 period also brought into the Medicaid program a beneficiary group that, by definition, has extensive acute medical care needs. The number of nondisabled adult beneficiaries who did not receive cash welfare payments more than doubled over the period--from 1.4 million to 2.9 million--and payments for that group rose from \$1.5 billion to \$6.5 billion.



### Increases in Payments to Providers

During the 1980s, providers in several states filed lawsuits challenging the reasonableness and adequacy of Medicaid's reimbursement rates for hospitals and nursing homes. Those lawsuits were filed under the Boren Amendment (originally enacted as part of the Omnibus Reconciliation Act of 1980 and expanded in the Omnibus Budget Reconciliation Act of 1981), which required states to pay rates that were "reasonable and adequate" to meet those costs that would be incurred by "efficiently and economically operated" facilities. A decision by the U.S. Supreme Court in 1990 established that providers have an enforceable right to such rates and that they may sue state officials for declaratory and injunctive relief.

Following the Supreme Court's ruling, decisions favoring providers were handed down in several states. The mere threat of a suit under the Boren Amendment may have been sufficient to make some states increase payments. Even though recent court decisions have favored the states in suits brought under the Boren Amendment, the National Governors' Association is trying to have the amendment repealed. Some states are concerned that the Boren Amendment limits their ability to use managed care effectively to control Medicaid expenditures. It is not clear, however, what effect repealing the Boren Amendment would have on Medicaid spending.



## Financing Schemes and Disproportionate Share Payments

In the late 1980s and early 1990s, many states developed financing schemes to generate part of their share of Medicaid expenditures. Those schemes, which involved voluntary donations from providers, taxes on providers, and inter-governmental transfers, drew down federal matching dollars for what were often illusory Medicaid expenditures.<sup>4</sup> Such financing mechanisms were closely linked to the rapid growth in DSH payments that occurred during the period (sometimes as a response to actual or potential litigation under the Boren Amendment). According to researchers at the Urban Institute, DSH payments rose from less than \$1 billion in 1990 to more than \$17 billion in 1992.<sup>5</sup> But taxes or donations from providers almost certainly offset some of the state share of those amounts. Consequently, the actual spending on health services attributable to DSH was less than nominal DSH payments.

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4. General Accounting Office, *Medicaid: States Use Illusory Methods to Shift Program Costs to the Federal Government* (August 1994).

5. John Holahan, David Liska, and Karen Obermaier, *Medicaid Expenditures and Beneficiary Trends, 1988-1993* (Washington, D.C.: Urban Institute, September 1994).

