

MEDICAID: CHOICES FOR 1982 AND BEYOND

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ERRATA

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MEDICAID: ISSUES FOR 1982 AND BEYOND

Page 3: The last sentence in the first paragraph should read: "The federal share of Medicaid--the total amount of the federal government grants to states--is expected to exceed \$18 billion in 1982 and to reach \$24 billion in 1986, drawing attention to what is now widely called the 'Medicaid crisis'."

Page 14: The second line in TABLE 2 should read "Unemployed^b"

PREFACE

The Congress is now considering alternatives for reducing the cost of the Medicaid program. This paper, prepared at the request of the Senate Budget Committee, examines the background and consequences of a wide range of choices that would curb and refocus federal outlays for Medicaid. In keeping with the Congressional Budget Office's mandate to provide objective and impartial analysis, this study offers no recommendations.

Thomas J. Buchberger, of the Human Resources and Community Development Division of CBO, prepared the paper, under the supervision of Paul B. Ginsburg and Nancy M. Gordon. The author wishes to acknowledge the technical and critical contributions of many people, particularly Malcolm Curtis, Cynthia F. Gensheimer, John Holahan, Jack Knowleton, Sophie Korczyk, Lynn Paquette, Andy Schneider, and Bruce Vavrichek. Numerous people at the U. S. Department of Health and Human Services and officials of state Medicaid programs gave useful technical assistance. Johanna Zacharias edited the manuscript, and Toni Wright typed the many drafts and prepared the final paper for publication.

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SUMMARY

Medicaid is the joint federal and state program that, since 1966, has paid for much of the medical care of specific categories of low-income Americans. Federal law governs certain aspects of Medicaid. In particular, it mandates coverage of two particular groups of low-income persons: single-parent families, and some two-parent families with one unemployed parent, that receive cash assistance through the Aid to Families with Dependent Children (AFDC) program; and aged, blind, or disabled persons who receive aid from the Supplemental Security Income (SSI) program. The federal government requires states to provide a basic set of services to people eligible for Medicaid, and to reimburse providers of those services in certain ways. Reimbursement levels for certain services are subject to federally established ceilings and in some instances, floors.

In other respects, however, states have certain flexibility in administering Medicaid. Their influence on eligibility, for example, is considerable, because states establish eligibility for AFDC, which, in turn, establishes eligibility for Medicaid. (The same does not hold true for SSI recipients, whose eligibility is determined primarily by federal criteria.) Furthermore, states may voluntarily extend Medicaid coverage to additional groups of people and expand the range of services covered. States also have considerable discretion in how they reimburse physicians and certain other medical providers.

FEDERAL COSTS

The magnitude of Medicaid expenditures has reached what many legislators consider to be critical levels. Funding for Medicaid reimbursement comes from both state and federal sources. The federal share--determined by formula and based on state expenditures, and varying inversely with state per capita income--will exceed \$18 billion in 1982, and under current policies, it is likely to rise to \$24 billion by the end of 1986.

THE MEDICAID POPULATION AND PROGRAM TARGETING

Recipients of AFDC and SSI constitute about 60 percent of the noninstitutional population eligible for Medicaid and 70 percent of those who receive program benefits; however, they account for only 57 percent of program expenditures. The remaining eligible population is demographically similar to the cash assistance population but for some reason does not actually receive transfer payments. For example, children who are members of low-income families that do not qualify for AFDC, perhaps because both parents are present, constitute a large portion of this group.

The Medicaid population--some 28.6 million in 1980--is a mix of persons above and below the federal poverty level. Because of the program's combination of federal and state eligibility criteria, many low-income people fail to qualify for Medicaid; at the same time, a certain number of people with relatively high annual incomes are covered. About 12 million persons with incomes below the federal poverty threshold are now ineligible. On the other hand, about 5 million of those eligible have annual family incomes in excess of two times the poverty standard, in part because of the use of monthly accounting periods in state determinations of AFDC eligibility. Most of these 5 million persons are children.

HOW PROGRAM FUNDS ARE SPENT AND TO WHAT EFFECT

Program expenditures are heavily weighted toward institutional services, especially long-term care. Expenditures for care in nursing homes constitute 42 percent of program costs, and inpatient hospital care represents 28 percent. The remaining 30 percent goes primarily for physicians' services, outpatient hospital care, and medications.

The use of health-care services by low-income persons has increased during Medicaid's history. Large numbers of Medicaid recipients are cared for by practitioners specializing in Medicaid patients, rather than in the settings that serve many patients with higher incomes.

The health of the poor, along with that of the rest of the population, seems to have improved somewhat, although Medicaid's role in this change cannot be readily distinguished from other factors. By at least one measure--infant mortality--Medicaid appears to have had a beneficial effect on recipients' health. Nevertheless, the health of the poor continues to lag behind that of the general population.

FACTORS AFFECTING MEDICAID OUTLAYS

High and rising Medicaid expenditures have dominated attention during the current budgetary debate over funding for health services. Total program costs depend on four factors over which federal and state governments have varying degrees of control:

- o Eligibility,
- o Benefits,
- o Price and use of medical care, and
- o Reimbursement levels.

Not counting nursing home care, per recipient expenditures--which are determined by benefits, the price and use of care, and reimbursement levels--have risen less rapidly than national per capita health-care expenditures.

Eligibility

The size of the Medicaid population is a factor in the program's high cost. The largest increases in cost occurred before 1975, largely because of expansions of eligibility. The program reached its all-time peak in 1977, with 22.9 million recipients, and it could reach that level in 1982 as a result of increases in the AFDC recipient population.

Beyond 1982, a decline in the size of the largest segment of the eligible population will tend to reduce program costs. The number of persons eligible for Medicaid on the basis of receipt of AFDC and SSI is projected to decline. An increase in the proportion of disabled recipients of SSI--who are more expensive to serve--will limit any spending reductions associated with declines in the cash-assistance population.

Benefits

Broad coverage of medical services contributes to Medicaid's high cost. The addition of new services by the federal government since the beginning of the program has not been a major factor,

however; Medicaid has always offered a wide array of services. Likewise, the occasional decisions by some states to add benefits after their programs were in operation have also played a relatively minor role.

The Price and Use of Medical Services

Purchasing in the private medical care market subjects Medicaid to the prevailing trends in the prices and use of medical care services. With the exception of nursing home care, Medicaid expenditures make up only a small share of the medical care market, and this limits the extent to which Medicaid can influence trends in the prices and use of medical care. Both the prices and use of medical care are expected to continue rising over the next five years, which will lead to higher Medicaid outlays.

Reimbursement Levels

States have not had full freedom to use what purchasing power they have to obtain the lowest prices for some types of care. Federal law limits state flexibility in setting reimbursement rates for institutional services such as hospital care. Also, because states cannot purchase most types of care through competitive bidding, they cannot buy certain supplies, laboratory services, or other services at the lowest possible prices. States have already used their wide discretion in physician reimbursement to set fees significantly below those charged private patients; this in part explains the constrained increase in per recipient expenditures.

OPTIONS FOR REALLOCATING MEDICAID EXPENDITURES

The modifications in Medicaid now before the Congress would reduce program expenditures. Just as states have in the past tried to curb Medicaid costs without limiting eligibility, most current choices avoid direct reductions in numbers of people eligible. The Administration's proposal would limit federal financing of state programs. Other options would change the programs's benefits or the federal government's requirements for reimbursement to providers. In recent years, the eligibility

changes the Congress has considered would have increased the number of low-income persons eligible for Medicaid. Observance of tight budgetary constraints would necessitate reducing expenditures for some current recipients if eligibility were granted to persons who cannot now qualify for Medicaid.

The options the Congressional Budget Office has examined include such reallocations to improve targeting. Other options would trim benefits, adjust reimbursement methods, or alter the federal role in Medicaid in some fundamental ways. (Ways to curb growing cost of long-term care, which are not now a focus of Congressional attention, are not examined here.)

Target Eligibility on the Most Needy

Incremental changes in Medicaid's eligibility criteria could extend coverage to some low-income persons not now qualified for Medicaid. For example, states could be required to cover all low-income children, regardless of whether or not their families qualify for AFDC. Mandatory Medicaid coverage for the 4.7 million low-income children now not eligible would raise federal Medicaid costs by somewhat more than \$100 million in 1982.

Alternatively, better targeting could be achieved by terminating eligibility for some of the less needy, such as recipients of only the optional state payments that supplement SSI. Some 600,000 persons would lose automatic Medicaid eligibility, and federal Medicaid costs could fall by some \$300 million in 1982.

Alternatively, the federal government could require states to adopt a minimum national eligibility standard; this would impose a degree of uniformity on eligibility policies. For example, providing acute care (but not nursing home care) through Medicaid to all those whose annual incomes were below 55 percent of the federal poverty standard, while excluding those with yearly incomes in excess of twice the poverty standard, would result in coverage of an additional 7 million persons now ineligible. At the same time, eligibility for about 5 million persons would end. Federal expenditures would rise by \$1.9 billion in 1982, and state costs by \$1.5 billion. Most of the people who would be newly eligible would be among categories that are currently ineligible for Medicaid regardless of income, such as single adults.

Change Benefits, Expand Cost Sharing, or Liberalize Reimbursement Policies

Federal support could be eliminated for certain services. For example, coverage of dental care could be cut to save about \$360 million. The savings could be used either to trim expenditures or to expand eligibility.

Modifying federal law to require Medicaid recipients to share the costs of hospital and physicians' services could decrease expenditures by \$700 million in 1982 because of lower payments to providers and reduced use of services. Although cost sharing may now be applied to some services, it has rarely been applied to the use of hospital and physicians' services. Use of this technique could cause some recipients to defer necessary care or result in some shifting of costs to other patients, however.

Allowing states to depart from the current "reasonable cost" method and exercise greater freedom in hospital reimbursement rate setting would probably lead to lower Medicaid expenditures for inpatient care. A number of states have demonstrated an interest in containing program costs by seeking to lower hospital reimbursement rates, but federal guidelines and administrative procedures have impeded such efforts. If states had greater flexibility in setting hospital reimbursement rates, they could set rates at whatever minimal levels would attract an adequate number of hospitals. Lower hospital reimbursements could, however, limit Medicaid patients' access to care and cause some of the costs of treating Medicaid patients to shift to other patients.

If states could buy laboratory services, drugs, and other equipment in volume through competitive bidding, about \$90 million could be saved in 1982. The use of contract purchasing of care could be extended to hospital care. This could reduce federal costs by an additional \$50 million in 1982, although Medicaid patients might lose some freedom of choice.

Modify the Federal Role in Financing Medicaid

Rather than modify eligibility, benefits, or reimbursement requirements, the federal government could alter the extent to which it shares Medicaid costs with the states. Either federal outlays could be limited, or calculation of the federal share could be modified.

Impose a Ceiling on the Federal Matching Funds to States. The Administration has proposed a cap--that is, an indexed limit--for federal Medicaid outlays that would save \$900 million in 1982 by allowing only a 5 percent increase from the 1981 level. Spending in 1981 would be held at \$100 million below the current base estimate for 1981. In future years, the cap on Medicaid expenditures would be adjusted to reflect changes in inflation as measured by the GNP deflator. Each state's share of the capped federal expenditures would be based on that state's percentage of federal Medicaid expenditures in 1981. The Administration plan would also give states greater flexibility to limit eligibility, restrict services, and lower reimbursement levels.

What effect the cap would have on people who are currently eligible cannot now be estimated, because states' responses to the cap are unpredictable. In part because the allocation of federal expenditures to some states would be significantly different from that of recent years, the effects would vary from state to state. States that would be most adversely affected by the cap are those in which Medicaid expenditures can be expected to rise most rapidly under current policies. Both higher-than-average growth in states' low-income populations and large price increases would not be accommodated under the cap. Also, states that have actively sought to restrain Medicaid costs in the past and those with the most limited programs would soon have to consider eligibility and benefit cuts.

Reduce the Minimum Federal Share. By lowering the statutory minimum matching rate from 50 to 40 percent, federal Medicaid expenditures could be reduced by about \$700 million in 1982 and by \$1.6 billion in 1986. The 13 states affected by the elimination of the minimum federal share could use state funds to replace lost federal support, but they would probably reduce eligibility, benefits, or reimbursement levels somewhat because of state budgetary constraints.

End States' Responsibility for Costs and Administration. The federal government could assume all responsibility for financing and administering Medicaid. This shift of responsibility could be effected either with or without a change to uniform eligibility criteria. The federal government might be better able than states to restrain increasing medical care prices and use of services, although there is no general agreement on this point. Also, the

federal government would be in a better position to take advantage of any economies of scale in program administration. On the other hand, states might be in a better position to experiment because of their long experience administering Medicaid.

Provide Incentives for State Program Expansion. By matching state Medicaid outlays for some persons not now eligible, such as single persons and childless couples, the federal government could encourage expansion of Medicaid. The federal government could also give each state a supplemental grant for increased eligibility; but the reluctance of states to make additional expenditures and the uncertainty of future funding for supplemental grants would tend to limit the effect of this option.

PART I. BACKGROUND AND REVIEW OF PROGRAM EXPERIENCE

Under Medicaid, the federal government shares with states the costs of providing medical care to low-income people. States and territories may choose whether or not to operate Medicaid programs, and at present, all but Arizona do so. States directly reimburse medical-care providers for services rendered to Medicaid patients. At the federal level, the program is administered by the Department of Health and Human Services (HHS). The federal share of Medicaid--the total amount the federal government grants to states--is expected to exceed \$18 billion in 1982 and to reach \$28 billion in 1986, drawing attention to what is now widely called the "Medicaid crisis."

THE EVOLUTION OF FEDERAL SUPPORT FOR
MEDICAL SERVICES FOR THE POOR

The enactment in 1965 of Medicaid and its companion program, Medicare, followed 15 years of gradual growth in federal involvement in supporting medical care for the poor.¹ The administration of Medicaid is patterned after the joint federal/state structure of the cash assistance programs, Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI). Eligibility for AFDC and the separate assistance programs for the aged, blind, and disabled that preceded SSI was enacted in 1935 and evolved around the concept of "the deserving poor."² The primary focus of AFDC and SSI was intended to be on persons whose economic

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1. The Medicare program was designed to provide medical services primarily for the elderly and for certain disabled persons. Both programs were enacted as amendments to the Social Security Act in 1965.
 2. Joel Handler and Ellen Jane Hollingsworth, The Deserving Poor: A Study of Welfare Administration (Markham, 1971), pp. 16-26.

status is beyond their control--dependent children, and the aged, blind, and otherwise disabled. Although the administration of welfare benefits under AFDC has generally been a state function, the federal government assumed responsibility for the aged, blind, and disabled in implementing SSI.³

Until 1950, states and local governments alone financed the small amount of publicly supported medical care available to low-income people. In 1950, the federal government began to share state expenditures that paid for medical services for public assistance recipients. Federal participation remained limited to a percentage of the amount of cash and in-kind medical benefits, up to maximum dollar amounts.

In 1960, however, federal involvement in financing health care for low-income elderly people increased significantly with the implementation of the Kerr-Mills program.⁴ Under the Kerr-Mills program, states were allowed by federal law to expand their medical assistance programs to include elderly people whose incomes, after subtracting medical expenses, were below state standards. These beneficiaries were identified as the "medically needy." The federal government, sharing program costs with state governments, contributed open-ended matching funds for each state's Kerr-Mills program. The federal government paid a percentage of each state's program; the federal share--a grant to cover a portion of state medical assistance expenditures--was determined by a formula, and it varied inversely with state per capita income.

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3. The SSI program, adopted as part of the Social Security Amendments of 1972, replaced separate federal/state cash assistance programs for the aged, blind, and disabled with a single program financed and administered by the federal government.
 4. The Social Security Amendments of 1960 (Public Law 86-778). The program of health care for low-income elderly persons was named for the sponsors of the legislation that created it, Senator Robert Kerr of Oklahoma and Representative Wilbur Mills of Arkansas. For a discussion of this history, see Robert Stevens and Rosemary Stevens, Welfare Medicine in America (Free Press, 1974).

In the mid-1960s, the federal role in providing medical services to the poor expanded markedly with the introduction of Medicaid. The new program, designed along lines similar to the Kerr-Mills program's, broadened the scope of coverage to other welfare recipients who were not aged and allowed states to extend medically needy coverage to them. An original goal of the Medicaid program was to provide comprehensive care to all those whose incomes were below certain state-established standards but this goal was later dropped. (Chapter II discusses Medicaid's eligibility criteria in greater detail.)

MEDICAL CARE AND THE POOR

Before Medicaid was introduced, most low-income persons received less medical care than did the rest of the population. For example, low-income people averaged 4.3 physician visits in 1964, compared to 4.6 visits for other persons. Prior to implementation of Medicaid, more low-income people than the average had had no medical care at all within a two-year period. The limited amount of medical care financing provided through the welfare system left many poor people to rely on public facilities such as municipal hospitals or on charity care offered by private doctors.

Instead of creating a separate system of medical care for the poor, however, the Medicaid program established a system of direct reimbursement, through state agencies, to mainstream private-sector health-care providers. The program is known to have succeeded in increasing the use of medical care by the poor, although not always from mainstream providers. Some feel that Medicaid has improved health among the poor, but data with which to test this hypothesis is scant. (In Chapter III, this difficult question is examined further.)

Special characteristics of medical care that distinguish it from other purchased goods and services led to governments financing medical services directly, rather than indirectly by increased cash assistance. An individual's need for medical care and its costs are uncertain, with physicians (in effect, the vendors) making many of the purchasing decisions that in other markets are usually made by consumers.⁵ Many people buy health insurance to

5. See also Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," American Economic Review, v. 53, no. 5, December 1963.

deal with this uncertainty. But the framers of the Medicaid legislation believed that increases in cash assistance might not necessarily be spent on medical care or health insurance.⁶ Without some assurance that augmented benefits would be spent on medical care, people eligible for Medicaid might not increase their use of medical care, and providers would continue to provide uncompensated care to low-income persons. Hence, the direct reimbursement approach of Medicaid was designed.

ISSUES FOR THE 1980s

The high and rising cost of Medicaid, and whether the program benefits the people who need it most, are central issues in the current Medicaid crisis and the focus of this study. In spite of the program's high cost, about one-half of all people in families with incomes below the federal poverty standard cannot benefit from Medicaid. At the same time, some people with annual incomes above the federal poverty level have access to Medicaid. These observations suggest that the way Medicaid is administered could be better tailored to meeting program goals as well as to curbing costs.

Some of the options for resolving Medicaid's present cost problems and its coverage of the low-income population are examined in this paper. To establish a basis for analyzing possible changes in the Medicaid program, the remainder of Part I reviews the mechanisms of the program and their effects--how eligibility is determined, who benefits and who does not, and to what extent the program has succeeded in its goal of improving access to medical care of the poor. Part I also analyzes the causes of Medicaid's current high cost. In Part II, four sets of options reflecting different approaches to modifying the Medicaid program are presented.

This analysis of Medicaid and options for modifying the program excludes institutional long-term care services, even though these now account for more than 40 percent of program

6. For further discussion, see Stevens and Stevens, Welfare Medicine (Free Press, 1974).

costs. This is because most options under discussion by the Congress in recent years have not directly dealt with long-term care. Also, an adequate analysis of long-term care would have required consideration of several issues that are not confined to Medicaid.

CHAPTER II. ELIGIBILITY CRITERIA AND COVERAGE OF THE POOR

Because of Medicaid's eligibility criteria, program benefits are largely but not fully directed toward the most needy. Although more than 12 million poor persons are currently eligible, about one-half of all people with annual incomes below the federal poverty standard are ineligible for Medicaid.¹ At the same time, nearly 20 percent of the population eligible for Medicaid belongs to families with incomes above the poverty threshold. This uneven coverage of low-income persons results from a mixture of eligibility criteria set by both the federal government and states with Medicaid programs.

In requiring that Medicaid be available to persons receiving assistance under federal income maintenance programs, the federal government gives states significant flexibility to determine eligibility for some groups of persons but not for others. Low-income elderly, blind, and disabled persons who receive assistance through SSI must generally be included in the state-run Medicaid programs. Single-parent families, or some two-parent families in which one parent is unemployed, that receive AFDC must also be included in state Medicaid programs. The difference is that, under SSI, most eligibility decisions are made by the federal government, whereas, states determine the income eligibility standards for AFDC, which is a joint federal/state program.

States may also add to their Medicaid programs specific groups of people who do not receive cash assistance. Except for not being recipients of cash assistance, persons in the groups to whom states may grant Medicaid eligibility must resemble SSI and AFDC recipients. That is, they must be children or other members of single-parent families, or they must be aged, blind, or otherwise disabled. States may not extend Medicaid eligibility to single individuals, childless couples, and others who do not fit the categorical eligibility structure of AFDC or SSI. Table 1 summarizes the composition of the Medicaid recipient population with respect to mandatory coverage associated with SSI and AFDC and coverage voluntarily extended by states.

1. For 1980 income, the federal poverty standard for a nonfarm family of four was \$8,450.