Medicaid Responsiveness: A Preview of Research Results

Stan Dorn
Economic and Social Research Institute
2100 M St. NW, Ste. 605
Washington, DC 20037
www.esresearch.org
202.833.8877, ext. 14
sdorn@esresearch.org

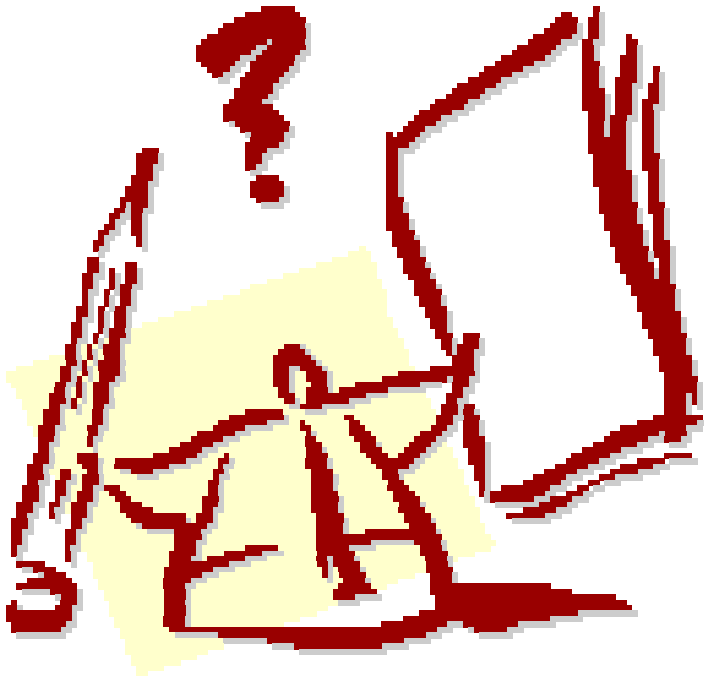
May 9, 2005
National Press Club

Overview

1. Proposals to cap federal Medicaid dollars
2. Implications of capping federal Medicaid dollars
   - Health coverage
   - Recovery from future recession
3. Policy alternatives
   - Achieving savings without capping federal Medicaid dollars
   - Enhancing Medicaid's responsiveness

Sources and notes are on the final two slides.

Major caveat: all that follows is very preliminary!



Current program responsiveness

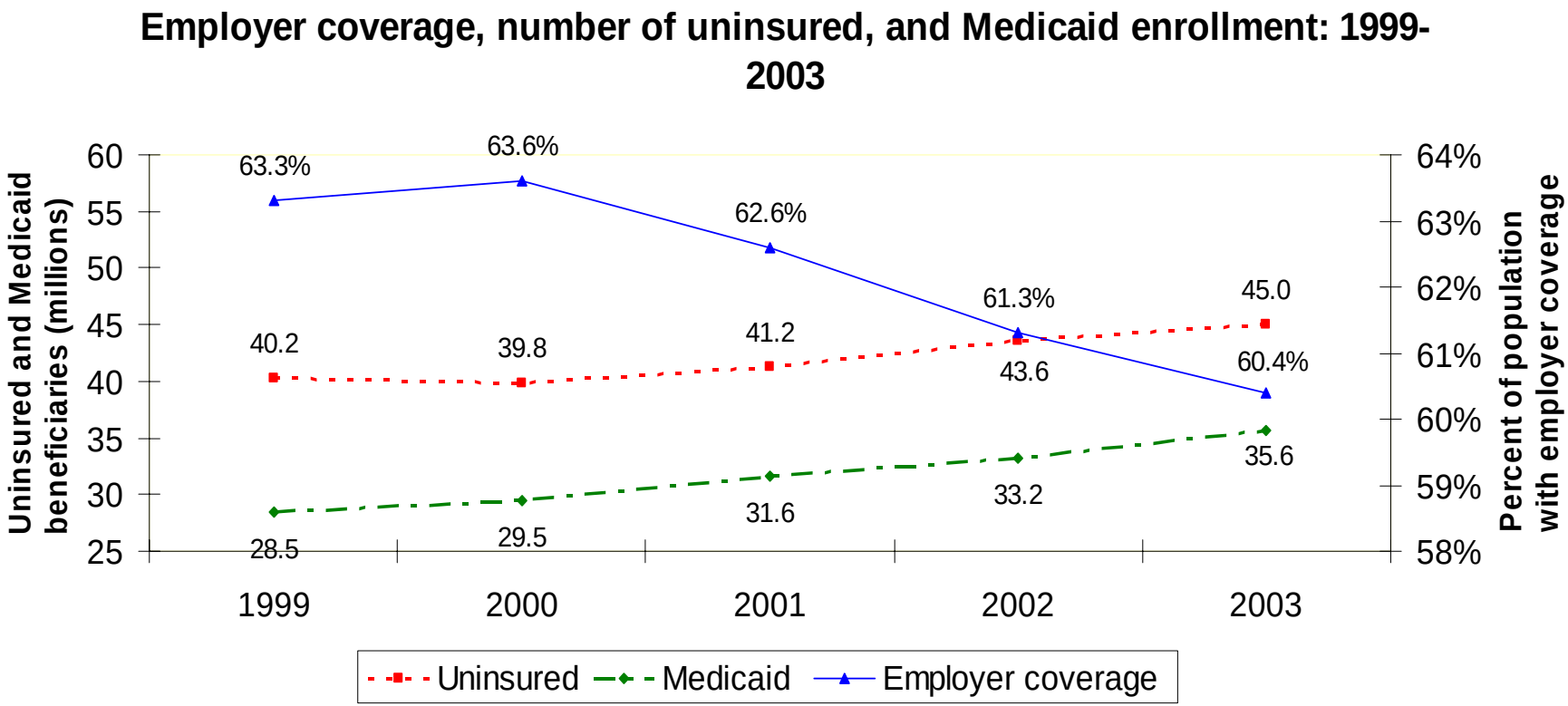
- Some Medicaid spending automatically responds to changed economic conditions
  - Individuals meeting eligibility criteria are guaranteed coverage
  - When economic conditions change so more individuals qualify, Medicaid coverage and spending increase automatically
  - States can control spending by changing program rules to limit:
    - Eligibility
    - Covered services
    - Reimbursement
- Federal dollars automatically reimburse a percentage of state spending
  - Federal match averages 57 percent of program costs

Proposals to cap federal Medicaid spending

- Medicaid block grant proposal passed by Congress and vetoed by President Clinton in December 1995
- Caps on federal Medicaid dollars proposed in President Bush's budgets for 2004 and 2005
  - Each state accepting long-term spending caps would have received short-term funding increases
- 7 out of 17 comprehensive waivers granted since January 2001 have enrollment caps
- HHS budget concept: with optional Medicaid spending, increase state flexibility while keeping federal dollars "budget neutral"
  - 65 percent of Medicaid spending is for optional services or eligibility groups

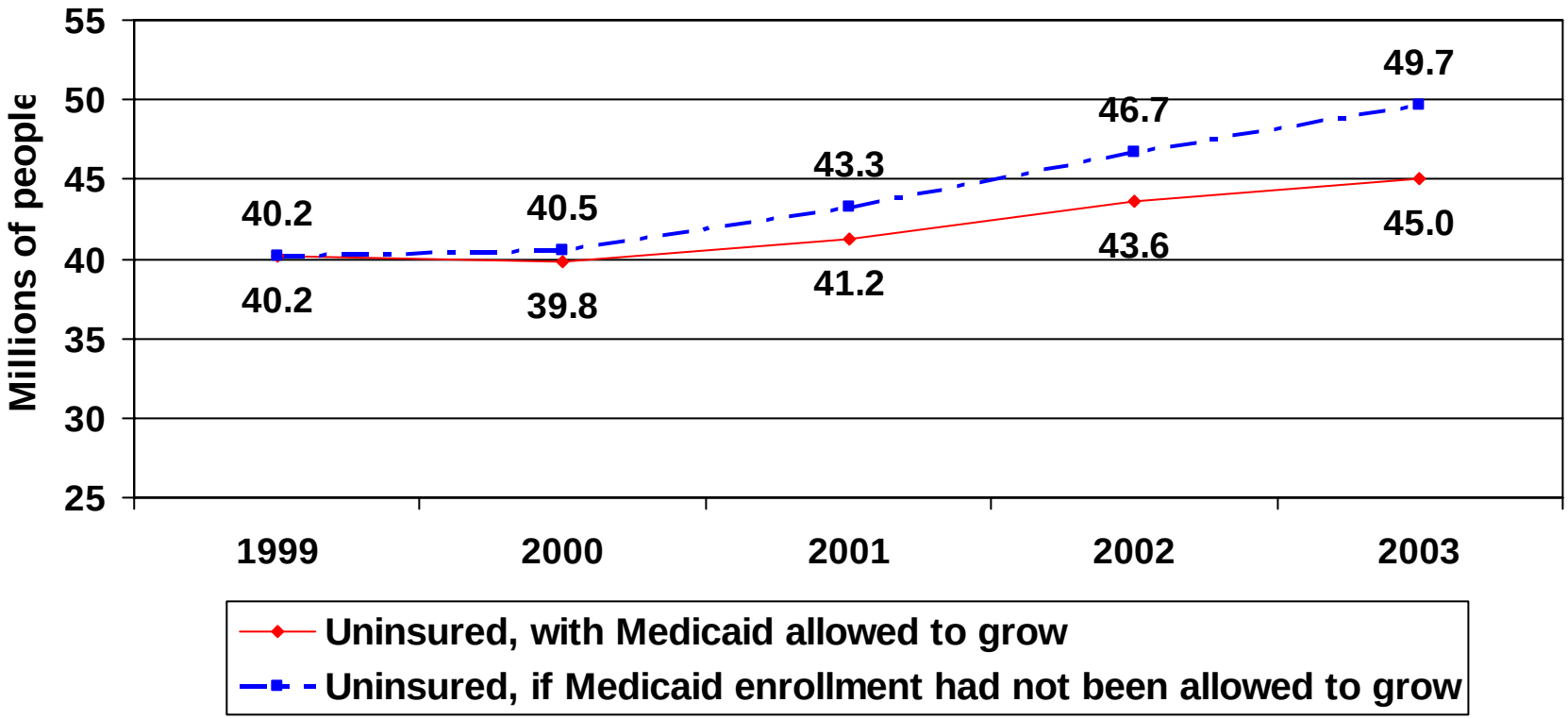
If caps prevent Medicaid from expanding when individuals lose coverage, more will be uninsured

Medicaid picked up much of the slack when employer coverage declined in recent years



Sources: U.S. Census Bureau (Current Population Survey, 2000 to 2004 Annual Social and Economic Supplements). Last Revised December 7, 2004. Calculations by ESRI, May 2005.

If Medicaid enrollment had not been allowed to grow since 1999, roughly 5 million more people would have been uninsured in 2003



Sources: U.S. Census Bureau, December 7, 2004 (see previous slide). Calculations by ESRI, May 2005. Note: Higher uninsured numbers reflect Medicaid enrollment capped at 1999 levels, with 33% of individuals losing Medicaid obtaining coverage from other sources, based on recent data about uninsurance among individuals losing Medicaid.

Health insurance is particularly important when people become unemployed

- Job loss increases incidence of:
  - Heart disease
  - Mental illness
  - Lung cancer
  - Domestic violence
  - Health problems of family members
- Uninsurance reduces access to services essential to detect and treat such health problems
- Overall, job loss increases mortality rates by 37% among previously healthy workers
- Note: during recession, Medicaid enrollment increases not just because of job loss but also because of lower earnings among the employed

If Medicaid spending cannot increase during recession, future economic downturns may deepen

Widespread agreement that Medicaid plays a countercyclical role

- Some automatic expansion during recession
  - No need for policymakers to make a policy decision – hence timely stimulus
- Agreement by
  - Federal Reserve
  - CBO
  - Urban Institute
    - If the unemployment rate rises from 4.5 to 5.5 percent, the number of Medicaid beneficiaries increases by 1.5 million
    - If the unemployment rate rises from 4.5 to 6.5 percent, the number of beneficiaries grows by 3.3 million.

The impact of Medicaid responsiveness on the overall economy is unknown

- Part of Medicaid is not countercyclical
  - Policy changes unrelated to the business cycle can affect Medicaid enrollment
    - Example: enactment of the State Children's Health Insurance Program in 1997 increased Medicaid enrollment among children
    - Example: when the Olmstead decision increased Medicaid's provision of home- and community-based care, Medicaid became more attractive to the elderly and disabled, raising their enrollment

Macroeconomic impact is unknown, Part II

- Aspects of Medicaid that are not countercyclical, continued
  - General health care cost increases affect Medicaid along with other payers
  - Economic trends not directly related to the business cycle affect Medicaid enrollment, such as ongoing declines in employer coverage
- To authoritatively determine Medicaid's macroeconomic impact, analysts should use highly developed models of the entire economy
  - That would be costly and time-consuming. Policymakers would not receive an answer in time for consideration during this year's budget debate.

Based on what we know now, is there a serious risk of economic harm if Medicaid spending is capped so that it cannot grow automatically during recession?

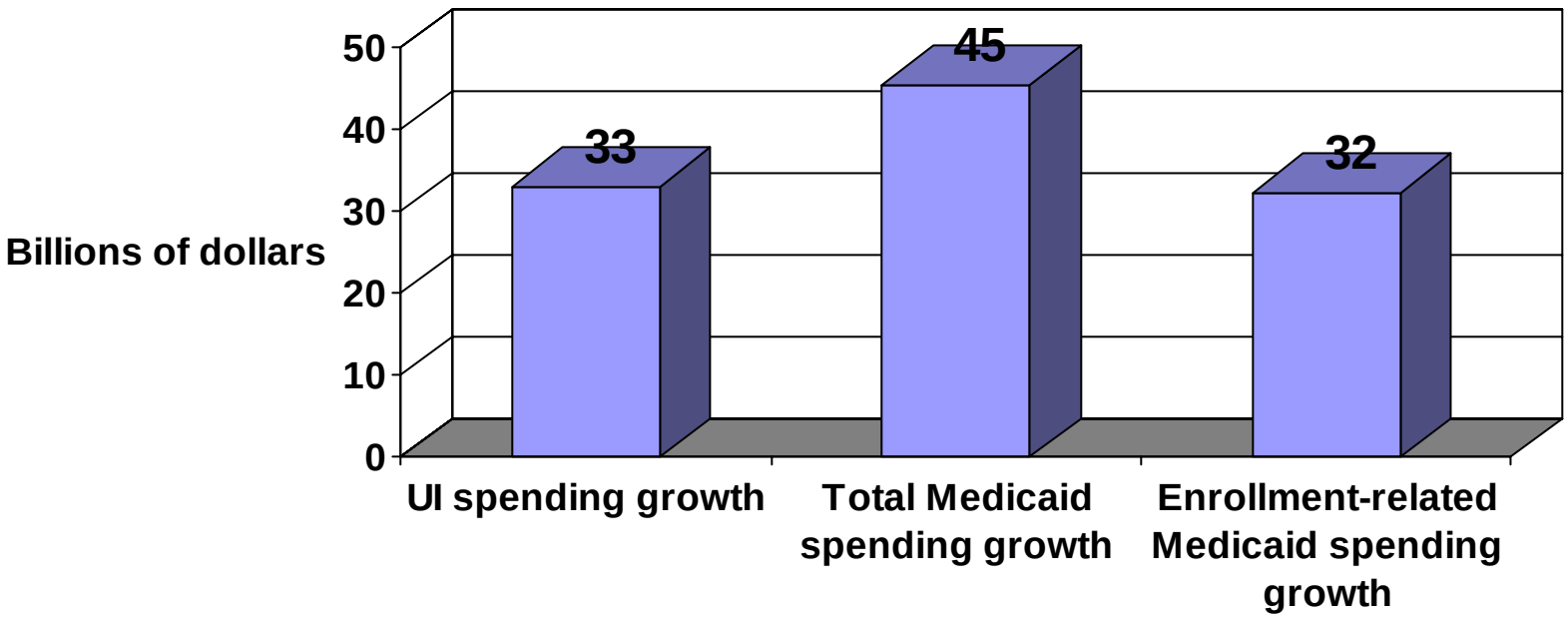
Rigorous macroeconomic modeling has shown that unemployment insurance (UI) is a major factor moderating economic downturns

- 1999 study sponsored by the U.S. Department of Labor, using Wharton Econometric Forecasting's Quarterly Model (WEFA Model)
- During the five recessions beginning after 1969, the UI program:
  - Mitigated the loss in real GDP by 15-17 percent
  - Saved 131,000 jobs during the average recession's peak year
  - Served as one of the country's most important fiscal stabilizers

Are Medicaid's counter-cyclical components comparable in magnitude to UI?

During the recent economic downturn, Medicaid spending growth resulting from higher enrollment nearly equaled UI spending growth

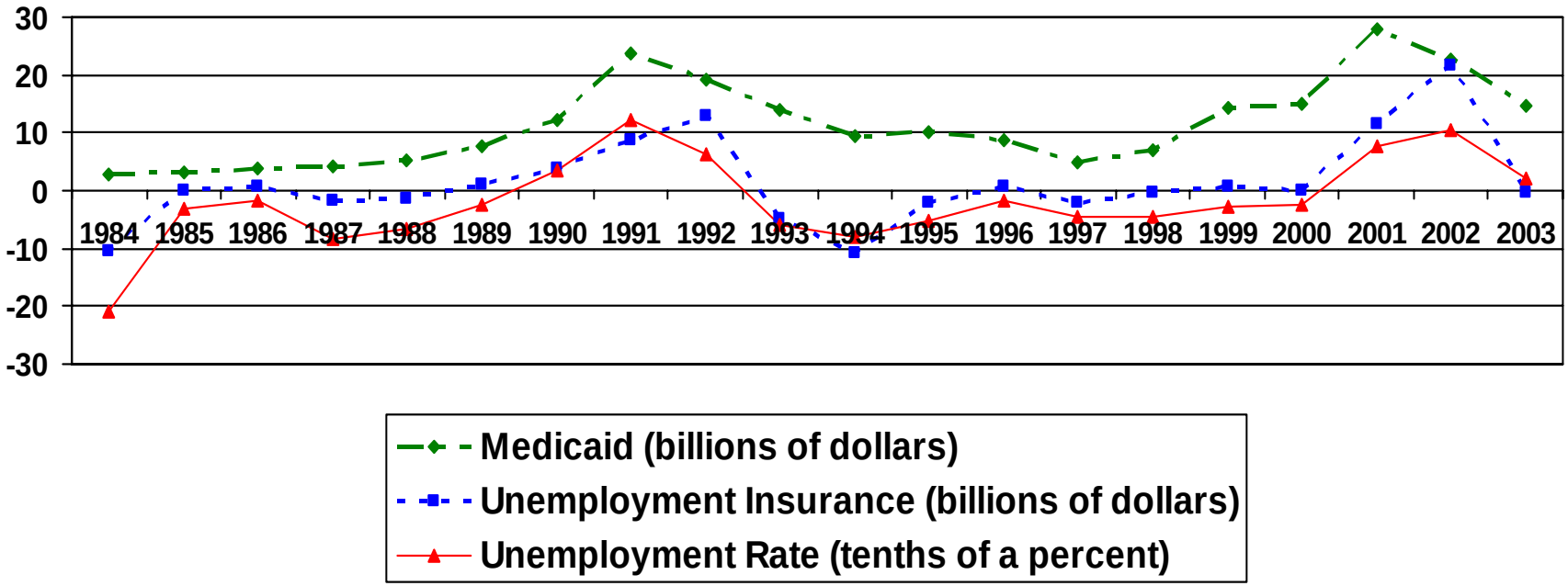
Spending increases, UI vs. Medicaid: 2000-2002



Sources: Urban Institute analysis of Medicaid spending growth, January 2005; Bureau of Economic Analysis (BEA), U.S. Department of Commerce, National Income and Product Account (NIPA) data on UI spending. Calculations by ESRI, April 2005.

In the past two decades, changes in Medicaid and UI spending have paralleled changes in unemployment, with Medicaid providing more increased stimulus when unemployment rose

Changes in UI spending, Medicaid spending, and unemployment rates: 1984-2003



Source: NIPA Data, BEA, on Medicaid and UI spending; BLS data on unemployment rates. Calculations by ESRI, April 2005.

The African-American community has a large stake in this issue

- Among African-Americans, Medicaid covers:
  - 44 percent of all children;
  - 72 percent of poor children;
  - 38 percent of poor adults; and
  - 38 percent of poor seniors.
- Recession causes great harm in the Black community
  - Unemployment rates rise especially sharply for Black workers during economic slowdowns. For example, from 2001 to 2004, White unemployment grew by 0.9 percent (from 3.7 to 4.8 percent) while Black unemployment rose by 2.7 percent (from 8.1 to 10.8 percent).
  - Black households have fewer resources to fall back on during hard times. Median wealth for African-Americans is approximately $11,000 - literally one-tenth that of Whites.
- African-Americans disproportionately suffer from health problems like hypertension and diabetes. The health consequences from losing Medicaid or losing employment can thus be quite severe.

Policy alternatives

Medicaid cost growth can be reduced without capping spending or enrollment

- Bush Administration proposals for current budget
  - Limit asset transfers that qualify seniors for long-term care
  - Reduce states' ability to "game" the system financially
- Other ideas
  - Facilitate Medicaid fraud prosecutions by private bounty hunters
  - Increase use of home- and community-based care
  - Integrate systems of payment and care for dual eligibles
  - Increase state authority to incorporate employer coverage
  - Improve case management for the chronically ill
  - Tighten payment rules for prescription drugs
  - Increase multi-state capacity to leverage good prices through joint buying of prescription drugs, equipment and supplies, etc.
  - Implement community-based obesity prevention strategies
  - Limit cost growth for the overall health care system through, e.g., reforms to direct-to-consumer advertising and better information to providers, consumers, and payers about new technology

Should federal matching percentages rise automatically when recession hits?

Medicaid policy change now causes ***program contraction*** during recession

- In recession, Medicaid caseloads rise while state revenues drop – policy changes then dampen spending growth
  - Most state constitutions require balanced budgets
  - To meet those requirements, states typically cut Medicaid during economic slowdown. For example, in FY 2002-2003:
    - 50 states cut or froze provider payments
    - 46 states cut prescription drug payments
    - 25 states cut eligibility
    - 18 states cut benefits
    - 17 states increased beneficiary charges
  - Major cuts likewise occurred during the early 80s and early 90s
- States are thus forced to cut Medicaid precisely when:
  - Laid-off workers need the most help
  - The economy needs the most stimulus

During recession, UI policy changes cause ***program expansion***

- Extended Benefits (EB) are automatically provided, based on certain increases in state unemployment rates
- When state unemployment rates rise in certain other ways, states can further extend UI
- Federal policymakers traditionally provide some additional UI during recession

A promising option: countercyclical federal matching rates for Medicaid

- National policymakers legislated a 2.95% increase in federal match for 15 months, ending in June ‘04
  - Prevented or reduced Medicaid cuts in 31 states
- Promising option: make similar changes automatically in the future
  - Use national and state unemployment rates as triggers
  - Automatic adjustment of funding, without waiting for new federal legislation each recession, begins and ends stimulus promptly, yielding more targeted and effective help to the economy
  - Could preserve health coverage and strengthen the economy during future economic turndowns

Sources

Chart 5: Kaiser Commission on Medicaid and the Uninsured (KCMU), February 2005, *Medicaid's Optional Populations: Coverage and Benefits*, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51052. Samantha Artiga and Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, KCMU, March 2005, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52128.

Chart 7: U.S. Census Bureau. "Table HI-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1987 to 2003." *Historical Health Insurance Tables.* Last revised December 7, 2004. http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html. Note: the 1999 numbers in this slide incorporate the Census Bureau's adjustments made after the 2000 Census. Other 1999 numbers are less comparable to those for following years.

Chart 8: The estimated number of uninsured, if Medicaid enrollment had not been allowed to grow above 1999 levels, assumes that 67 percent of individuals denied Medicaid would have become uninsured, based on recent analyses of the percentage of individuals who became uninsured after losing Medicaid due to cutbacks in Oregon's Medicaid program. M. J. Carlson and B. Wright. *The Impact of Program Changes On Enrollment, Access, and Utilization In The Oregon Health Plan Standard Population*. Prepared by researchers at Portland State University and the Providence Center for Outcomes Research and Education for The Office for Oregon Health Policy and Research. March 2, 2005. http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC.cohortflwup.03.05.rpt.pdf. The projected, higher level of uninsurance probably underestimates the impact of Medicaid caps on uninsurance, since it is based on Census data that misclassify some Medicaid enrollees as uninsured. C. L. Peterson and A. Grady. *Medicaid/SCHIP Enrollees: Comparison of Counts from Administrative Data and Survey Estimates*. Congressional Research Service Memorandum. Updated March 30, 2005. http://www.aei.org/docLib/20050407_CRSMemoonMedicaidUndercount.pdf

Chart 9: See C. D. Mathers and D. J. Schofield, "The Health Consequences of Unemployment: The Evidence," *Medical Journal of Australia*, Vol. 168:178-182, 1998; P. Martikainen, T. Volkonen, "Excess Mortality of Unemployed Men and Women during a Period of Rapidly Increasing Unemployment," *Lancet* 348: 909-912, 1996; K. A. Moser, P. O. Goldblatt, A. J. Fox, D. R. Jones, "Unemployment and Mortality: Comparison of the 1971 and 1981 Longitudinal Study Census Samples," 1 *BMJ* 86-90, 1987; M. Linn , R. Sandifer, S. Stein, "Effects of Unemployment on Mental and Physical Health," *Am J Public Health,* 75:502-506, 1985; S. Shortt, "Is Unemployment Pathogenic? A Review of Current Concepts with Lessons for Policy Planners," *Int J Health Sci,* 26: 569-589, 1996; R. L. Jin, C. P. Shah, T. J. Svobada, "The Impact of Unemployment on Health: A Review of the Evidence," *Canadian Medical Association Journal*, 153 (5): 529-540, 1995.

Chart 11: D. Cohen and G. Follette, *The Automatic Fiscal Stablilizers: Quietly Doing Their Thing*, Federal Reserve Board, December 1999, http://www.federalreserve.gov/pubs/feds/1999/199964/199964pap.pdf; Congressional Budget Office (CBO), *The Budget and Economic Outlook: Fiscal Years 2003-2012*, January 2002, http://www.cbo.gov/ftpdocs/32xx/doc3277/EntireReport.pdf; CBO, *Changes in Participation in Means-Tested Programs,* April 20, 2005, http://www.cbo.gov/ftpdoc.cfm?index=6302&type=1; John Holahan and Bowen Garrett, *Rising Unemployment and Medicaid*, Urban Institute, October 16, 2001, http://www.urban.org/UploadedPDF/410306_HPOnline_1.pdf.

Sources (continued)

Chart 15: L. Chimerine, T. S. Black, and L. Coffey. *Unemployment Insurance as an Automatic Stabilizer: Evidence of Effectiveness Over Three Decades.* Coffey Communications, LLC, for U.S. Department of Labor. July 1999. Unemployment Insurance Occasional Paper 99-8. http://wdr.doleta.gov/owsdrr/99-8/99-8.pdf.

Chart 17: J. Holahan and A. Ghosh, "Understanding The Recent Growth In Medicaid Spending, 2000–2003," *Health Affairs.* Web Exclusive, Jan. 26, 2005, http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52v1; Bureau of Economic Analysis (BEA), U.S. Department of Commerce, *National Income and Product Accounts Table, Table 3.12., Government Social Benefits*, Last Revised on August 05, 2004, Calculations by ESRI, April 2005. http://www.bea.gov/bea/dn/nipaweb/TableView.asp?SelectedTable=108&FirstYear=2002&LastYear=2003&Freq=Year

Chart 18: BEA, op cit. Calculations by ESRI, April 2005.

Chart 19: U.S. Census Bureau, Table HI08, *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children Under 18: 2003*, Last revised: June 25, 2004, http://ferret.bls.census.gov/macro/032004/health/h08_000.htm; Census Bureau, Table HI03. *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Poor People in the Poverty Universe: 2001*, Last revised: July 14, 2004, http://ferret.bls.census.gov/macro/032002/health/h03_005.htm; Bureau of Labor Statistics, U.S. Department of Labor, Website Public Data Query, Series ids. LNS14000003Q, LNS14000006Q, *Seasonally adjusted, quarterly unemployment rates, Whites and Blacks*, ttp://data.bls.gov/PDQ/outside.jsp?survey=ln; L. Mishel, J. Bernstein, S. Allegretto, *The State of Working America: 2004-05*, Economic Policy Institute, September 2004, http://www.epinet.org/content.cfm/books_swa2004; Centers for Disease Control and Prevention, National Center for Health Statistics, *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2002*, July 2004, DHHS Publication No. (PHS) 2004-1550, http://www.cdc.gov/nchs/data/series/sr_10/sr10_222.pdf.

Chart 23: V. Smith, R. Ramesh, K. Gifford, E. Ellis, V. Wachino. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*. Health Management Associates for KCMU. September 2003. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126.

Chart 24: U.S. Department of Labor, Office of Workforce Security, Division of Legislation. *Unemployment Compensation: Federal-State Partnership.* April 2005. http://www.ows.doleta.gov/unemploy/pdf/partnership2005.pdf.

Chart 25: KCMU. *State Fiscal Conditions and Medicaid.* November 2004. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49527.