Medicaid and Health Care Costs: Recent Trends

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Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003


^ Estimate is statistically different from the previous year shown at p<0.1: 2002-2003.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
Real State Collections Per Capita
by Fiscal Year, 1994-2004

In Billions of Dollars

SOURCE: Analysis by the Rockefeller Institute of Government of data from Advisory Commission on Intergovernmental Relations, the Tax Foundation, NCSL, and NASBO
Contributing Factors to State Budget Shortfalls in FY 2002

$6.9

Growth in Medicaid Spending

$61.8

Drop in Revenue Collections

Figure 5
Average Annual Percentage Change in Spending Per Enrollee by Service, 2000-2002

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td></td>
</tr>
<tr>
<td>Prescribed Drugs</td>
<td>8.8%</td>
</tr>
<tr>
<td>Other Services</td>
<td>10.0%</td>
</tr>
<tr>
<td>Prepaid/Managed Care</td>
<td>8.9%</td>
</tr>
<tr>
<td>Outpatient/Clinic</td>
<td>7.8%</td>
</tr>
<tr>
<td>Physician/Lab/X-Ray</td>
<td>6.0%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>5.3%</td>
</tr>
<tr>
<td>Long Term Care</td>
<td></td>
</tr>
<tr>
<td>Home/Personal Care</td>
<td>7.8%</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>6.9%</td>
</tr>
<tr>
<td>Mental Health Institutions</td>
<td>5.2%</td>
</tr>
<tr>
<td>ICFMR</td>
<td>2.2%</td>
</tr>
<tr>
<td>Total</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

SOURCE: Urban Institute estimates based on data from HCFA Financial Management Reports (HCFA-64/CMS-64).
Figure 6
Annual Change in Measures of Private Health Spending

- National Health Expenditures Per Capita¹
  - 2001: 7.8%
  - 2002: 7.1%

- Health Care Spending Per Person with Private Coverage²
  - 2001: 10.0%
  - 2002: 9.6%

- Private Insurance Premiums Per Person²
  - 2001: 13.0%
  - 2002: 12.0%

- Monthly Premiums For Employer-Sponsored Insurance³
  - 2001: 11.0%
  - 2002: 12.7%

Medicaid Enrollees and Expenditures by Enrollment Group, 2002

Enrollees
Total = 50.9 million

Expenditures
Total = $216 billion*

Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.

Contributors to Change in Medicaid Enrollment*, 2000-2002

Figure 8

- **Children**: 56% (3.7 million)
- **Adults**: 35% (2.3 million)
- **Blind/Disabled**: 6% (0.4 million)
- **Aged**: 3% (0.2 million)

Total Enrollment Growth = 6.6 Million

* Ever Enrolled

Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002

- Disabled: 34.3%
- Aged: 24.3%
- Aged and Disabled: 58.6%
- Children: 20.8%
- Adults: 15.4%
- Children and Adults: 36.2%
- *Other: 2.5%
- DSH: 0.7%
- Medicare Payments: 2.1%

Total = $48.2 Billion

* Other = Administrative costs and adjustments.

SOURCE: Urban Institute, 2003; estimates based on data from CMS, CMSO, Medicaid Statistical Information System (MSIS) and HCFA/CMS-64 Reports.
States Undertaking Medicaid Cost Containment Strategies, FY 2002 - FY 2004

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September and December 2003.
Why Medicaid Costs ≠ Health Insurance Costs

• Medicaid covers huge numbers of **medically uninsurable** Americans (increases costs)
  – Most Americans with Mental Retardation
  – Most Americans with Serious mental illness that began before or in early adulthood
  – Most Americans in Nursing Homes (~ 70% in Texas)
  – Many Americans with Disabilities acquired before adulthood

• Medicaid can/does pay some providers well below private market rates (lowers cost)
The Bigger Picture

• Congress’ message to the states in Medicare Rx Bill: Expect little or No fiscal relief for Medicaid costs of about 363,000 aged or disabled “dual eligibles” (who are on both Medicare and Medicaid). May even cost Texas MORE.

• The “low-hanging fruit” of Medicaid cost containment are gone. Many promising strategies improving medical care coordination (e.g., ways to maximize information technology to improve outcomes and reduce costs) to reap eventual savings may require up-front investment.

• OECD data show that the United States spends more on health care than any other country. However, on most measures of health services use, the United States is below the OECD median. These facts suggest that the difference in spending is caused mostly by higher prices for health care goods and services in the United States.

• Reducing Costs often means reducing profits and jobs.