

## State Initiatives to Reduce Medicaid Costs

Since 1965, Medicaid has provided access to comprehensive healthcare for low-income children, adults and senior citizens, and individuals with disabilities. In recent years, the Medicaid program has created fiscal burdens for states because of the increasing cost of healthcare and long-term care services. Covering close to 51 million low-income Americans, the Medicaid program spent close to \$216 billion in 2002 including \$1,514 per child, \$1,999 per adult, \$11,770 per individual with a disability, and \$13,099 per senior citizen. Growth in Medicaid spending on healthcare services is attributed to elderly beneficiaries and beneficiaries with disabilities, who demonstrated an increased use of prescription drugs.<sup>1</sup>

On average, more than 21 percent of total state budget is spent on Medicaid.<sup>2</sup> A major cost for Medicaid is long-term care (LTC), which covers over 406,226 children and 1.1 million adults. A recent study revealed that in 2002, Medicaid long-term care users accounted for seven percent of the Medicaid population, but approximately 52 percent of total Medicaid spending. Furthermore, 33 percent of elderly Medicaid enrollees made use of LTC services and accounted for 86 percent of all Medicaid spending. Per elderly Medicaid enrollee, the Medicaid program spent \$38,780. In addition to providing LTC services to the elderly, Medicaid enrollees with disabilities account for 15 percent of the Medicaid population but utilize 58 percent of the Medicaid budget.<sup>3</sup>

State revenues are unable to keep up with the growth of Medicaid fiscal expenditures and enrollment; and are looking to implement proposals that will reduce state expenditures towards the Medicaid program. Policy initiatives across the country are implementing changes in which financial risk and responsibility is spread among the states, federal government, and beneficiaries. These initiatives include:

- **Defined contribution** – the state is held accountable and limited to providing a pre-determined level of premium or allotment level for each beneficiary. In Florida, the Medicaid program is offering participating plans risk-adjusted premiums and allowing these plans to develop benefits that are covered by the specific risk-adjusted premium. Offering varying benefit packages will help meet the various healthcare needs of Florida's Medicaid beneficiaries. The state is solely responsible for setting up some sort of "defined contribution." It should be noted that federal funding is capped per person.<sup>4</sup>
- **Capitated payments** - the federal government creates a "global" cap on the total amount of Medicaid funds the state will receive for its Medicaid program based on the number of Medicaid enrollees. In Vermont, the Medicaid program can potentially reduce its benefits, increase cost sharing and cap enrollment in order to cover its beneficiaries after receiving a lump sum of federal dollars.<sup>4</sup>
- **Tiered benefits** – the state can separate its Medicaid enrollees into different levels related to their health status and provide benefit packages according to that status. Essentially, healthier enrollees have limited coverage and enrollees with poorer health have greater coverage.<sup>4</sup>
- **Cost-sharing** – shifts the cost of healthcare to the Medicaid enrollee either through premiums, deductibles, co-insurance and co-payments.<sup>5</sup>

Researchers have noted that states could face the risk of increased costs by implementing waiver caps since the federal government will not bear additional costs after paying the states a lump sum of money. Furthermore, a defined contribution in the Medicaid program might not be appropriate. Spending for healthcare services utilized by Medicaid beneficiaries is significantly different; and paying an average amount per Medicaid enrollee could result in overspending for enrollees that do not actually consume an average amount of services. The federal government also faces financial risks because waiver caps are set according to historical spending rates and "projected" rates of healthcare costs. These values are not necessarily accurate and federal spending could end up being more than what was projected.<sup>4</sup> Obviously, these initiatives have a significant impact on Medicaid enrollees since they could potentially reduce access to Medicaid services because of cost and eligibility barriers<sup>5</sup>, or not provide enough coverage because of what's outlined by the preexisting, tiered benefits packages.<sup>4</sup> It is important the state policymakers determine the demographics and needs of its Medicaid population before implementing new policy initiatives to help reduce state fiscal expenditures on the Medicaid program.



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**Sources:**

<sup>1</sup>Kaiser Commission on Medicaid and the Uninsured. (August 2003). *Medicaid: Fiscal Challenges to Coverage*. Accessed November 22, 2006 from <http://www.kff.org/medicaid/upload/Medicaid-Fiscal-Challenges-to-Coverage.pdf>.

<sup>2</sup>Pew Center on the States. (2006). *Special Report on Medicaid. Bridging the Gap Between Care and Cost*.

<sup>3</sup>Sommers Anna & Cohen, Mindy. (November 2006). Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns. Accessed November 22, 2006 from <http://www.kff.org/medicaid/upload/7576ES.pdf>.

<sup>4</sup>Mann Cindy and Artiga Samantha. (June 2006). New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility? Kaiser Commission on Medicaid and the Uninsured. Accessed November 22, 2006 from <http://www.kff.org/medicaid/upload/7507.pdf>.

<sup>5</sup>Ku, L and Wachino V. (2006). The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. *Center on Budget and Policy Priorities*.



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