MACPAC

Factors Driving Medicaid Spending Growth

Medicaid and CHIP Payment and Access Commission
April Grady

Overview

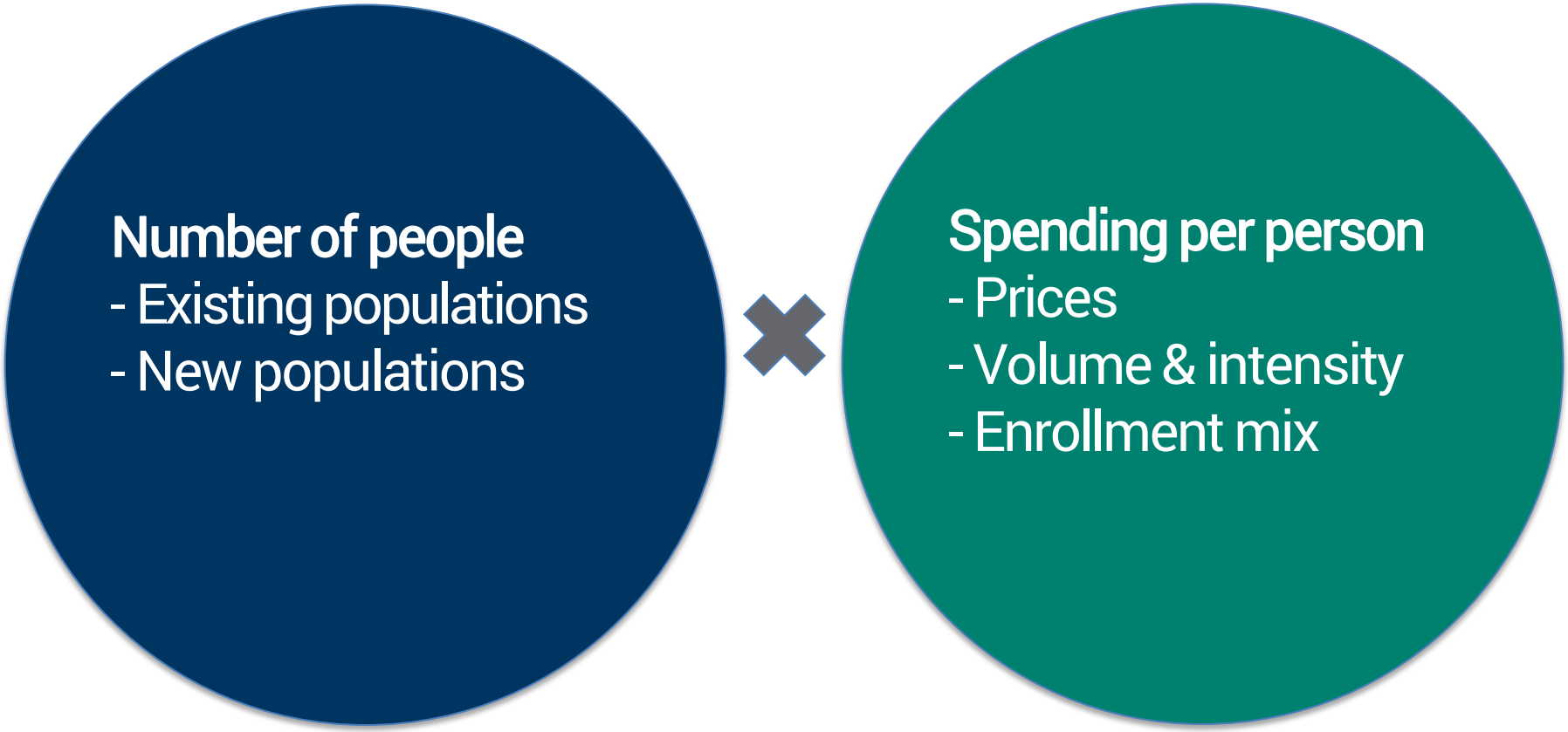
- Majority of historical growth in real (inflation-adjusted) Medicaid spending has been attributable to enrollment
- Reducing spending relative to current projections requires covering fewer people or lowering spending per enrollee
- New adults and those age 65 or older are the groups with fastest enrollment growth over the next decade
- Prices can be held down by reducing provider payments, but access to care is a concern
- Efforts to address volume and intensity of services may include a wide range of strategies

Facts on Medicaid Spending Growth

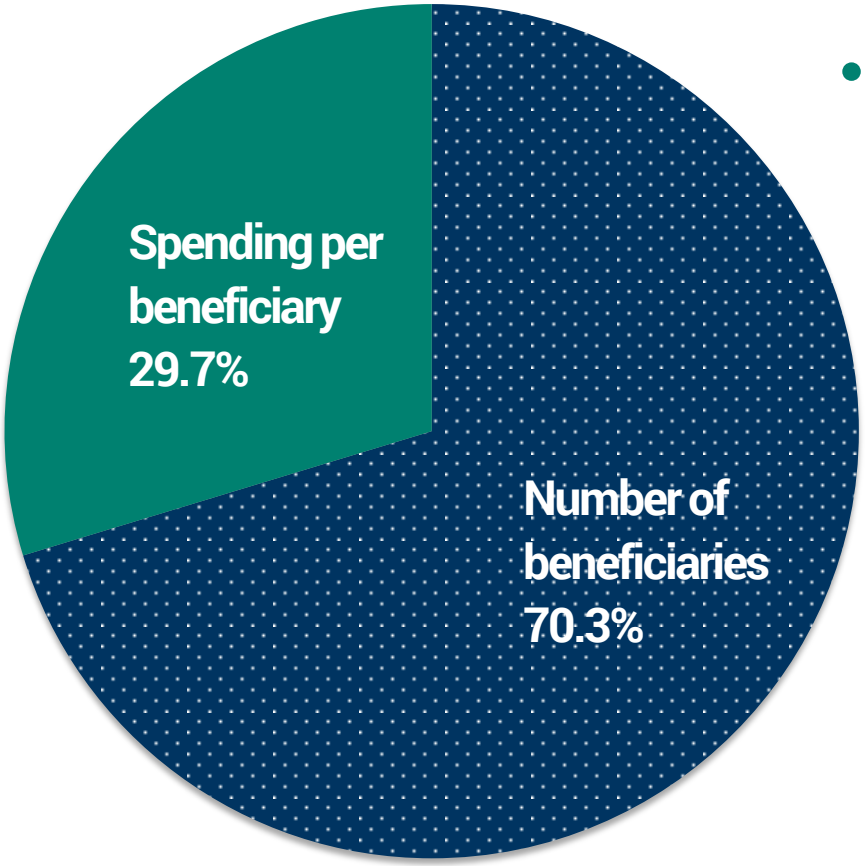
Historical Medicaid Growth

- From FY 1975 to FY 2010, more than two-thirds of real (inflation-adjusted) growth was due to increases in the number of beneficiaries and less than one-third was due to increases in spending per beneficiary
- About half of the growth was attributable to increased enrollment and spending per beneficiary for people eligible based on disability
- Growth rates and drivers, including policy changes and economic conditions, vary when looking at specific periods within larger window

Total Medicaid spending =



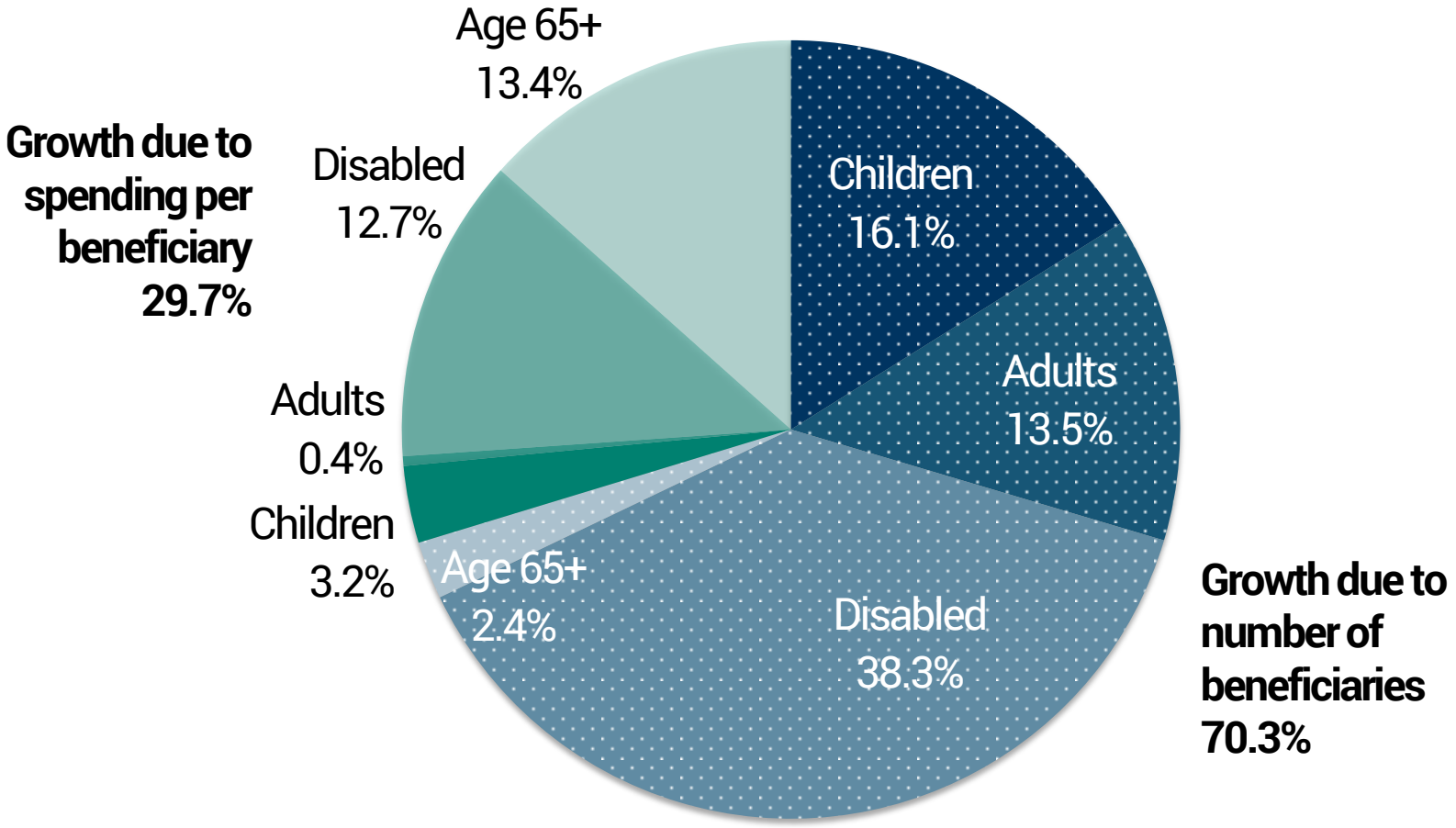
Components of Growth in Real Medicaid Benefit Spending, FY 1975–2010



- Majority of historical growth in real (inflation-adjusted) Medicaid spending has been attributable to enrollment

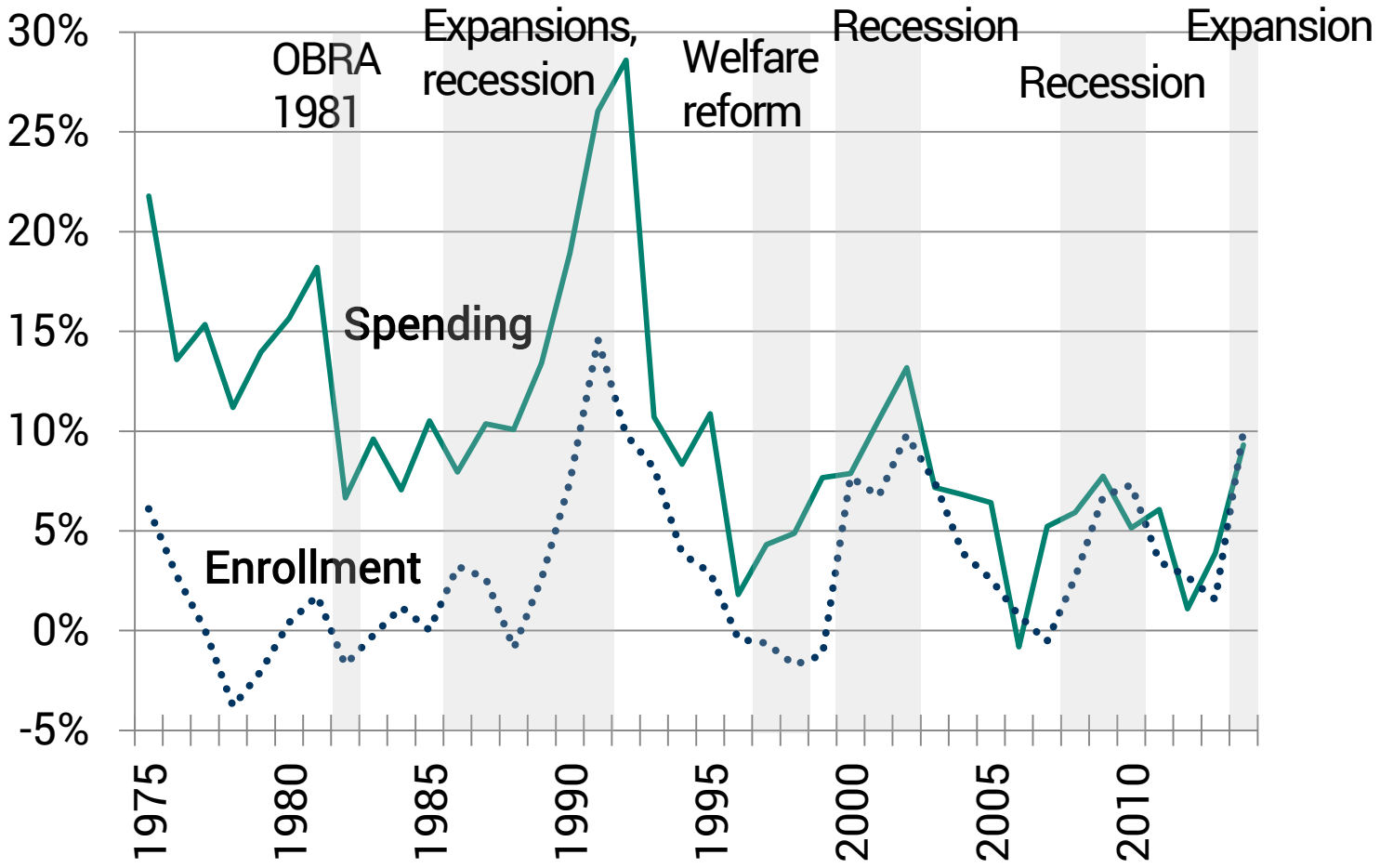
Note: Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.
Source: MACPAC, 2013, June MACStats Table 2.

Components of Growth in Real Medicaid Benefit Spending by Eligibility Group, FY 1975–2010



Note: Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.
Source: MACPAC, 2013, June MACStats Table 2.

Examples of Fluctuating Annual Growth in Medicaid Enrollment and Spending, FY 1975–2014

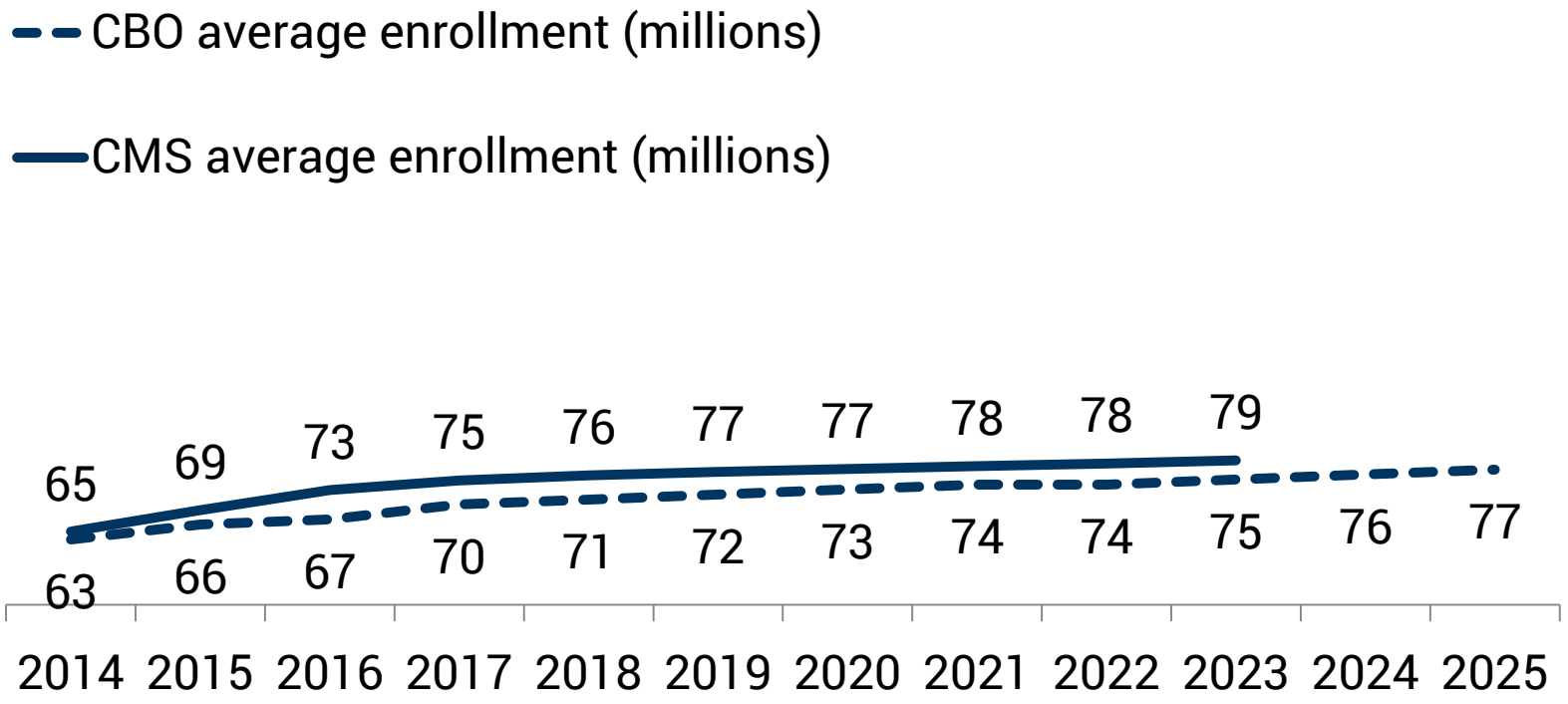


Note: OBRA is Omnibus Budget Reconciliation Act.
Source: Office of the Actuary, Centers for Medicare and Medicaid Services, 2015, Data compilation provided to MACPAC.

Projected Medicaid Growth: Federal

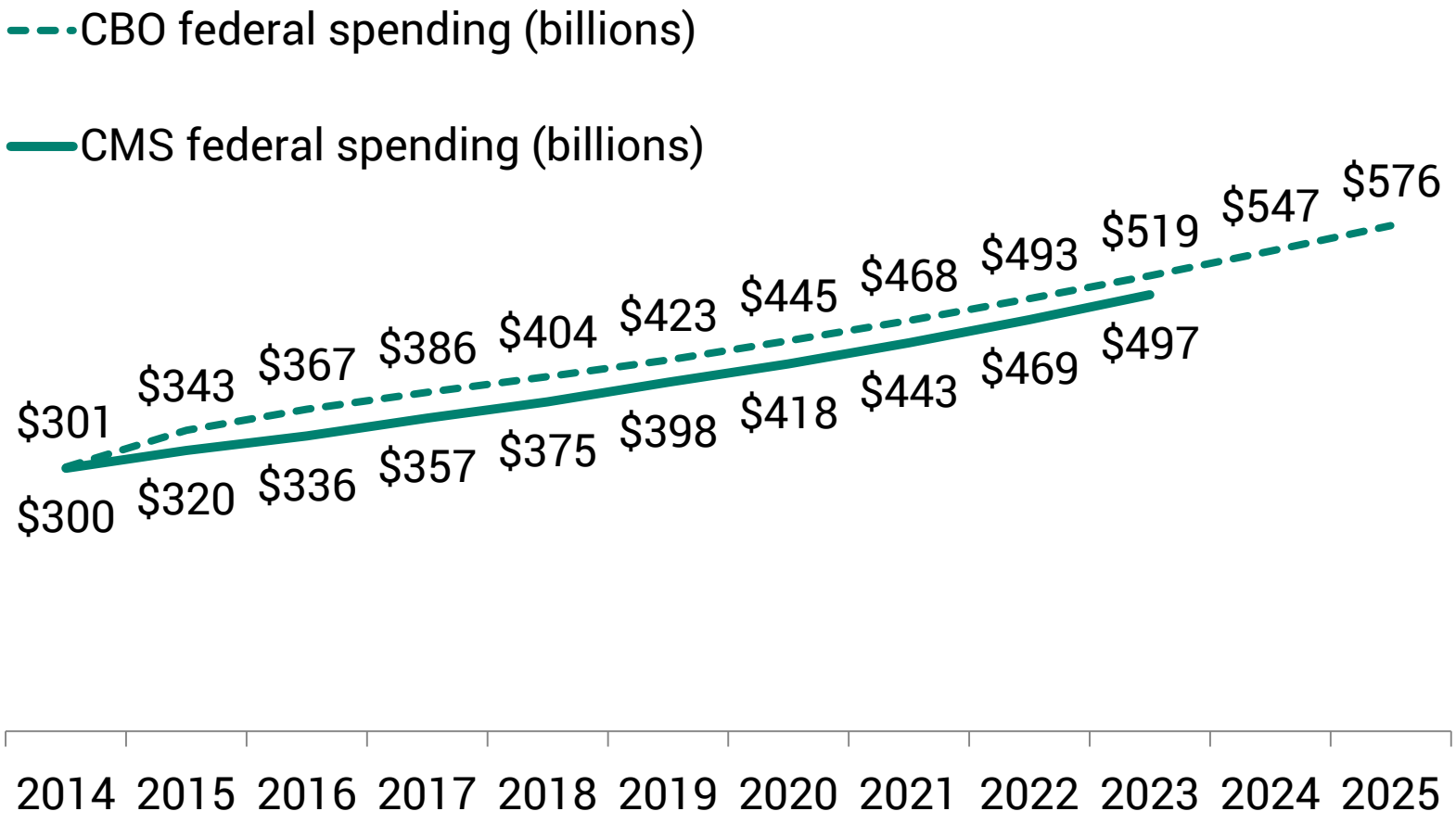
- Centers for Medicare & Medicaid Services (CMS) and Congressional Budget Office (CBO) estimates may differ
- Despite projected growth, Medicaid remains a smaller portion of the federal budget than Medicare
- Availability of higher federal share for new adult group affects the extent to which spending growth is financed with federal versus state dollars

CBO and CMS Medicaid Average Enrollment Projections, FY 2014–2025



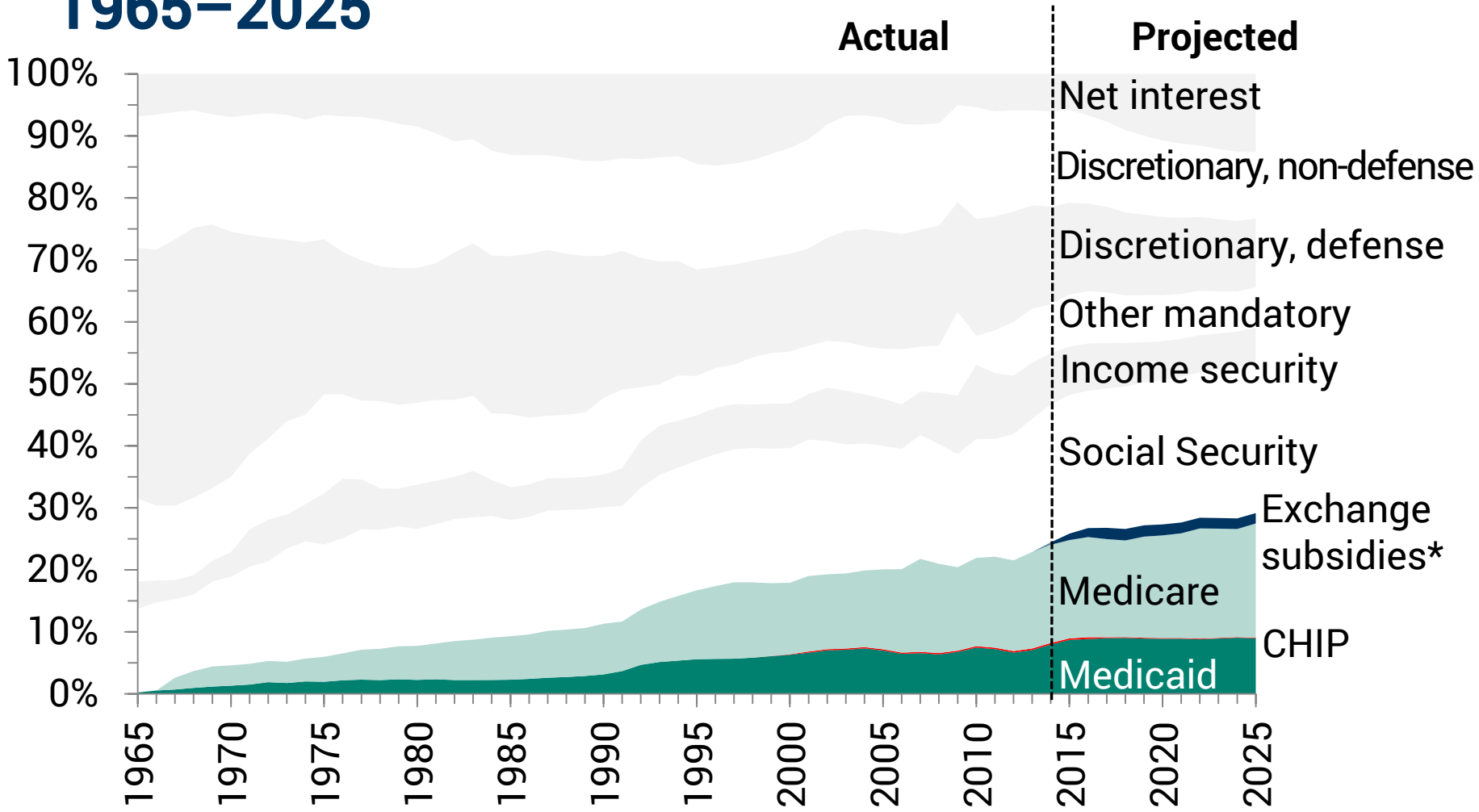
Note: CBO is Congressional Budget Office. CMS is Centers for Medicare & Medicaid Services.
Sources: CBO, *Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline* and CMS, *2014 Actuarial Report*.

CBO and CMS Medicaid Federal Spending Projections, FY 2014–2025



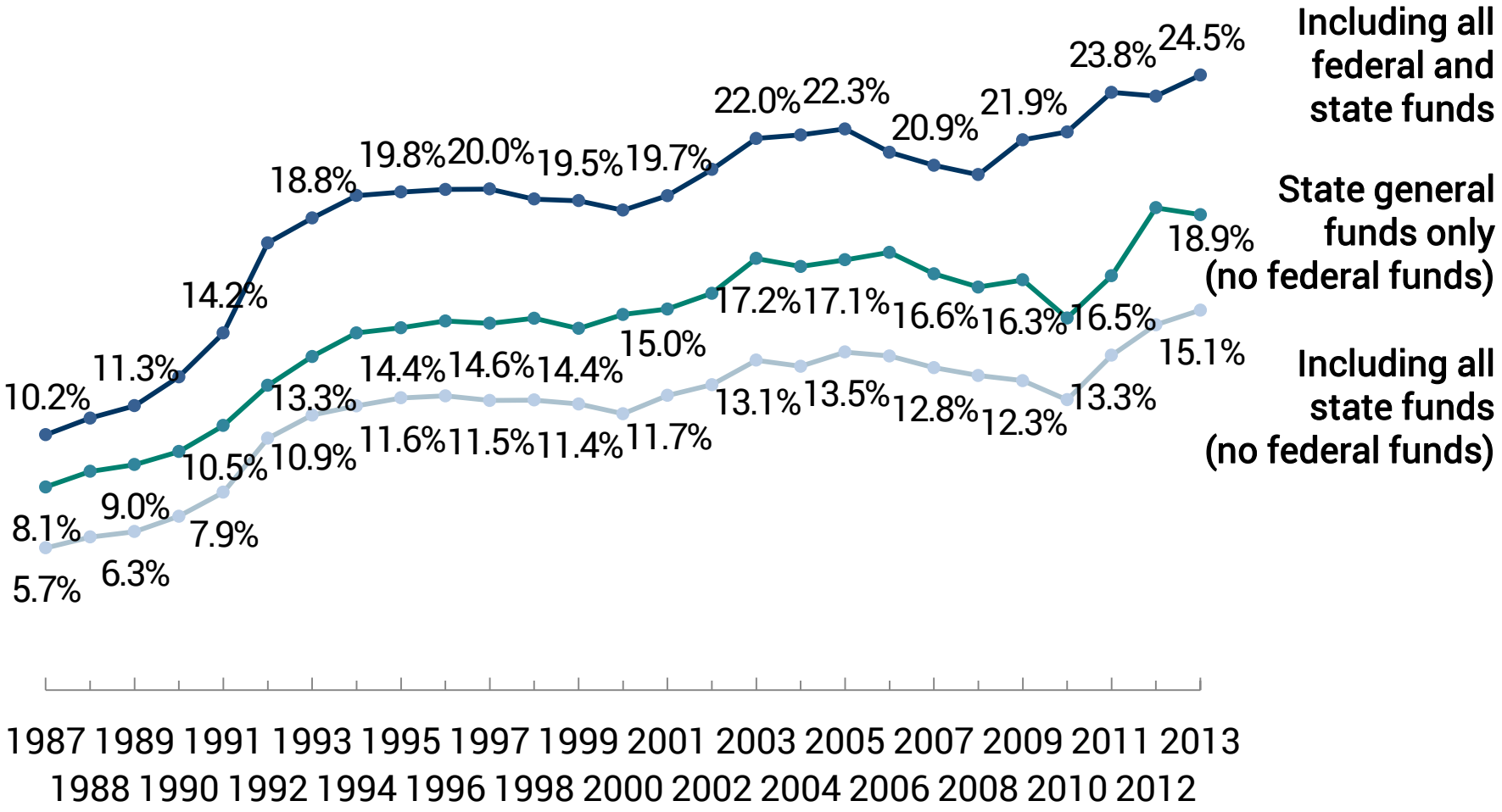
Note: CBO is Congressional Budget Office. CMS is Centers for Medicare & Medicaid Services. CBO released updated spending in August 2015, but spending from March 2015 is shown for consistency with enrollment estimates that have not been updated.
Sources: CBO, *Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline* and CMS, *2014 Actuarial Report*.

Major Components of Total Federal Outlays, FY 1965–2025



Notes: Amounts reflect gross outlays, which exclude Medicare premiums and other offsetting receipts.
* Reflects cost-sharing subsidies and the refundable portion of tax credits, but not any reduction in taxes owed.
Source: MACPAC analysis of data from Congressional Budget Office, *Updated Budget Projections: 2015 to 2025*.

Medicaid's Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2013

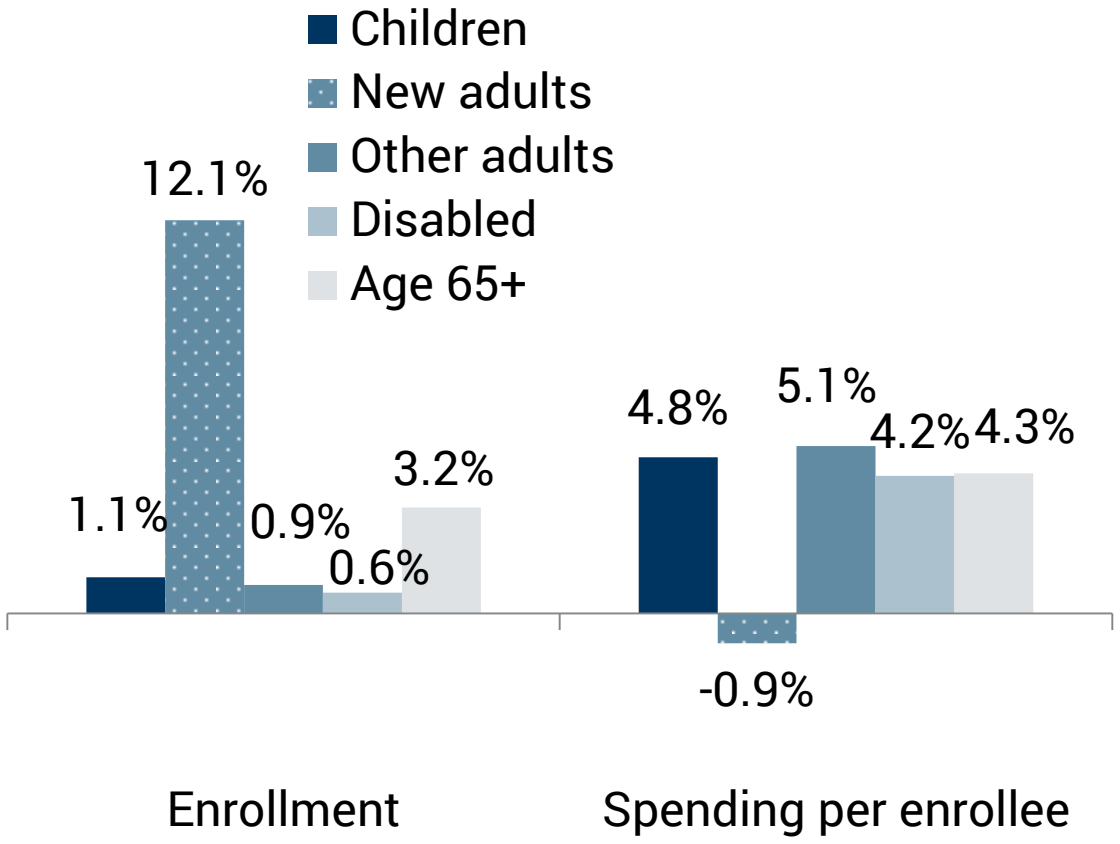


Source: MACPAC analysis of information from National Association of State Budget Officers.

Projected Medicaid Growth: Overall

- New adults and those age 65 or older are the groups with fastest enrollment growth over the next decade
- Growth in spending per enrollee is projected to be somewhat higher than medical inflation for all but the new adult group
- Coverage expansion, primary care payment increase, and new high-cost drugs are key items driving high spending growth projected for 2014
- Spending growth rates projected for 2015 and beyond are lower, reflecting moderation of expansion effects, expiration of payment increase, and negotiation with drug manufacturers

Average Annual Growth in Projected Medicaid Enrollment and Spending Per Enrollee, FY 2014–2023



- Medical CPI, one measure of price inflation, is projected to average 4.1% during this period
- Growth may also be compared to other benchmarks, such as GDP per capita

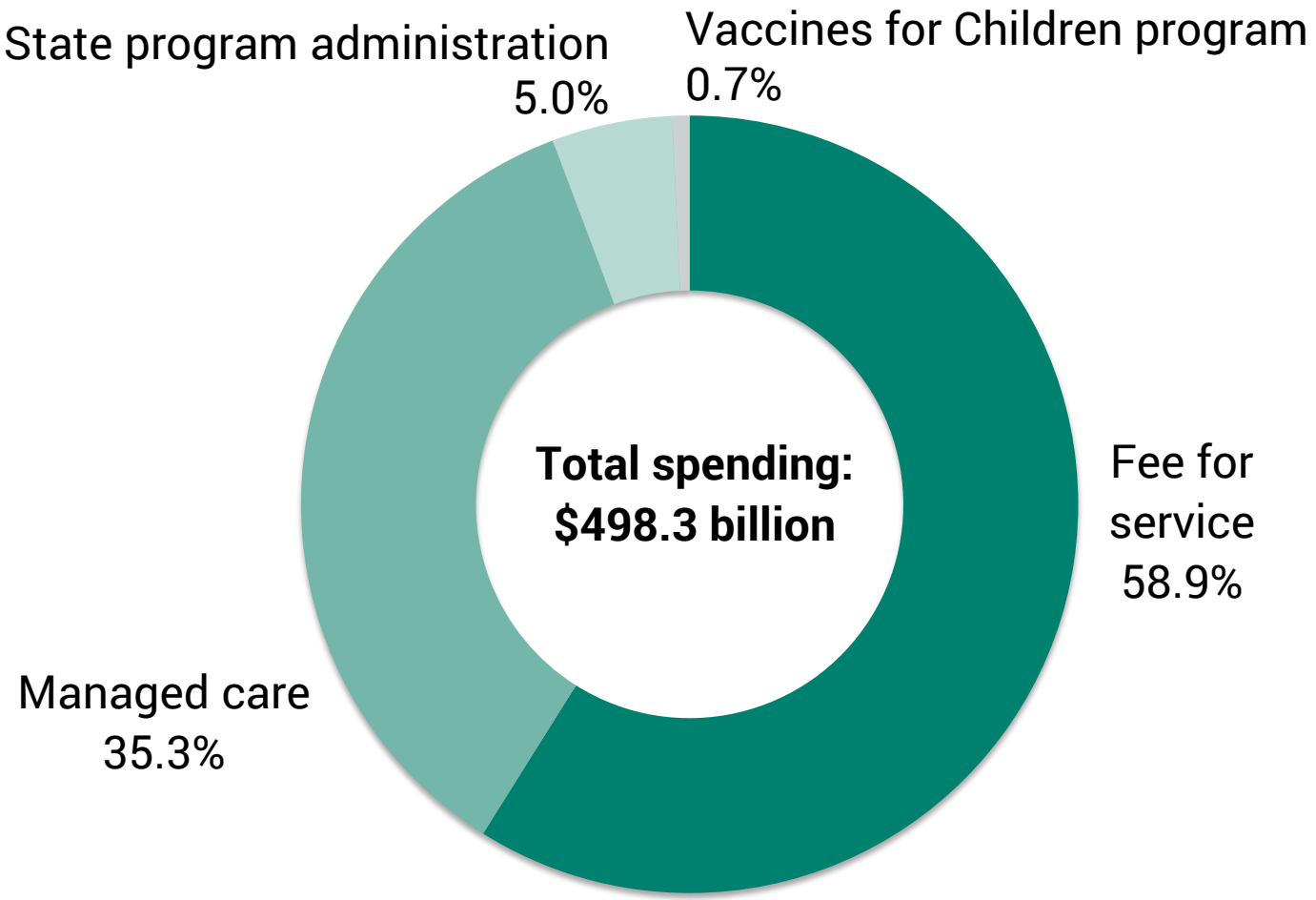
Note: CPI is Consumer Price Index. GDP is gross domestic product.
Source: MACPAC analysis of Centers for Medicare and Medicaid Services, *2014 Actuarial Report*, Tables 13, 15, and 16.

Distribution and Annual Growth of Medicaid Benefit Spending by Type of Service

Type of service	Share of benefit spending, 2013*	Average annual growth, 2006–2013	Projected growth		
			2014	2015	2016
Hospital	40%	6%	9%	9%	6%
Other health, residential, & personal care	20%	7%	2%	4%	5%
Physician & clinical	12%	7%	27%	6%	0%
Nursing & retirement facilities	11%	2%	1%	3%	4%
Home health	7%	8%	2%	7%	6%
Prescription drugs	5%	1%	23%	13%	3%
Dental	2%	8%	22%	13%	6%
Other professional	1%	5%	21%	15%	6%
Durable medical equipment	1%	4%	6%	9%	7%

* Components may not sum to 100% due to rounding.
Source: MACPAC analysis of Centers for Medicare and Medicaid Services, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960-2024 in PROJECTIONS format*.

Distribution of Total Medicaid Spending, FY 2014



Source: MACPAC, 2015 MACStats, *Medicaid spending by state, category, and source of funds* and *Total Medicaid benefit spending by state and category*, https://www.macpac.gov/macstats/.

Discussion of Factors Driving Medicaid Spending Growth

Medicaid Enrollment Can Grow without an Eligibility Expansion

- Population aging increases Medicaid enrollment, as low-income individuals gain eligibility when they turn 65 or need long-term services and supports
- Decreases in income during economic recessions also increase enrollment under existing eligibility rules, particularly among non-disabled children and adults

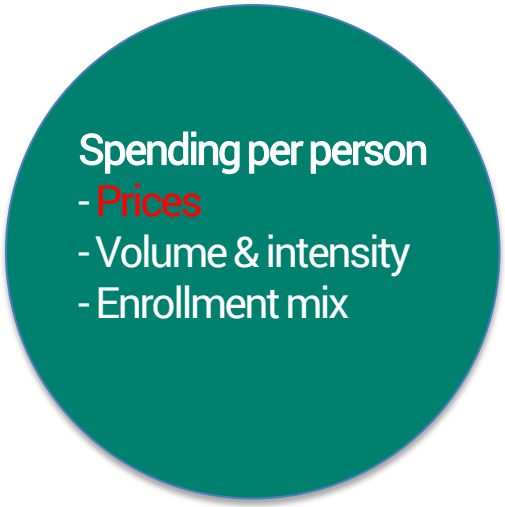
But Eligibility Policy Does Play an Important Role

- Newly eligible adults account for about 17 percent of the FY 2013-2023 increase in Medicaid benefit spending projected by CMS*
- Some states reduced eligibility levels for adults when maintenance of effort expired in 2014

- States are subject to maintenance of effort on eligibility for children through FY 2019

* MACPAC analysis of Centers for Medicare and Medicaid Services, *2014 Actuarial Report.*, Tables 15 and 16. Spending on all eligibility groups is projected to increase from $400.2 billion to $757.9 billion, while spending on newly eligible adults is projected to increase from zero (in FY 2013, prior to implementation of the new adult group) to $60.9 billion over the period.

States Have Some Control Over Prices



- States generally have discretion in setting provider payments
  - May or may not track with underlying growth in health care prices
  - May be influenced by mechanisms for financing state share
  - Must weigh effects on provider participation and beneficiary access
- States have less control over drug prices, which depend in part on the size of manufacturer rebates

Wide Range of Potential Strategies to Address Volume and Intensity of Services

- Limit or eliminate covered benefits
- Re-engineer delivery systems, which may involve changes to provider payment methods
- Change beneficiary incentives through cost sharing or other means
- Increase efforts to identify and prevent payment of improper or unnecessary services

Enrollment Mix Influences Overall Medicaid Spending Per Enrollee

- Per enrollee spending varies substantially across Medicaid eligibility groups
- As a result, overall Medicaid spending per enrollee is highly influenced by enrollment mix

- For example:
  - Overall Medicaid spending per enrollee is estimated to have increased by 0.3 percent in FY 2014
  - When changes in enrollment mix that reflected an influx of relatively low-cost adults are excluded, the estimated increase is 3.1 percent