CBO TESTIMONY

Statement of
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Medicaid Spending Growth and Options for Controlling Costs

before the
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Chairman Smith, Senator Kohl, and Members of the Committee, it is my pleasure to appear today to discuss the Medicaid program and the challenges it faces as a result of rising costs for health care and demographic pressures. The Congressional Budget Office (CBO) projects that under current law, federal spending for Medicaid will nearly double over the next 10 years—growing from $190 billion in fiscal year 2006 to $363 billion in 2015, at which point it will account for about 2 percent of gross domestic product (GDP). Spending by the states for Medicaid will increase correspondingly, placing further demands on states' budgets. But rising health care costs are also a significant issue for private payers and the economy as a whole, with the overall share of GDP spent on health care now projected to climb from 16.5 percent in 2006 to 20.0 percent in 2015.

My testimony today makes the following main points:

- Although 75 percent of Medicaid enrollees are children and their parents, 70 percent of spending for benefits goes toward care for the program's elderly and disabled enrollees.

- Past increases in spending for Medicaid have been driven partly by growth in enrollment but primarily by growth in costs per enrollee. In CBO's projections of future spending under current law, rising costs per enrollee play an even larger role, and those projections indicate that federal Medicaid spending will reach 4 percent of GDP by 2050.

- Medicaid spending per enrollee is determined by many of the same factors that continue to push up total U.S. health care costs, and the principal cause of those rising costs is the spreading use of new medical technology.

- Although a number of options are available for reducing federal Medicaid costs in the future, many of them involve shifting costs to the states or to enrollees.

- Because enrollees generally have low incomes and few assets, their ability to pay more for their care in many cases is limited. However, there is some evidence that Medicaid coverage discourages enrollees with higher incomes from buying private insurance or saving more to pay for their long-term care costs.

Overview of the Medicaid Program

Medicaid is a joint federal/state program that pays for health care services for a variety of low-income individuals. All those who meet the program's eligibility criteria are entitled to its benefits. In fiscal year 2006, federal spending for the program will total $190 billion, CBO estimates, $170 billion of which will cover benefits for enrollees. (In addition to benefits, Medicaid's spending includes payments to hospitals that treat a "disproportionate share" [DSH] of low-income patients as well as costs for the Vaccines for Children program and administrative costs.) The federal government's share of Medicaid's benefit spending varies among the states

but currently averages 57 percent. Although it is difficult to determine precisely how much the states spend on Medicaid (for reasons that are discussed later), CBO estimates that total federal and state spending for the program will exceed $300 billion for this fiscal year.[1] CBO also estimates that the Medicaid program currently covers 60 million people, or about 20 percent of the U.S. population.

Medicaid is thus the federal government's largest health care program in terms of enrollment, covering more people than Medicare does. In addition, total state and federal Medicaid spending is comparable to Medicare's net outlays. Several examples indicate the large role that Medicaid plays in the U.S. health care sector as a whole:

- It pays for about 40 percent of all births in the United States and covers about one-third of all children;
- It covers, according to surveys, about one-third of people whose income falls below the poverty level; and
- It finances about two-thirds of all nursing home stays by the time of a patient's discharge.

States administer their Medicaid programs under federal guidelines that specify a minimum set of services that must be provided to certain poor individuals. Mandatory benefits include inpatient and outpatient hospital services, physician and laboratory services, and nursing home and home health care. Mandatory eligibility groups include poor children and families who would have qualified for the former Aid to Families with Dependent Children program, certain other poor children and pregnant women, and elderly and disabled individuals who qualify for the Supplemental Security Income program. In general, a Medicaid enrollee must have both a low income and a low level of assets, although the minimum financial thresholds vary depending on the basis for an enrollee's eligibility.

Within broad statutory limits, states have the flexibility to administer the Medicaid program and determine its scope. Partly as a result, the program's rules are complex, and it can be difficult to generalize about the types of enrollees who are covered, the benefits that are offered, and the cost sharing that is required. States vary in how they count income and assets in determining eligibility for Medicaid. They may also choose to include additional eligibility groups (such as individuals with high medical expenses who have "spent down" their resources) or provide additional benefits (such as coverage for prescription drugs and dental services) and have exercised those options to varying degrees. Moreover, states often seek and get approval from the Department of Health and Human Services for waivers to provide benefits and cover groups that would otherwise be excluded under Medic-

1. Unless otherwise indicated, all data on program spending or enrollment presented in this testimony are for federal fiscal years.

aid. By one recent estimate, total spending on optional populations and benefits accounted for about 60 percent of the program's expenditures in 2001. Of that total, 30 percent was spent to provide optional benefits to mandatory groups; 50 percent, to provide mandatory benefits to optional groups; and 20 percent, to provide optional benefits to optional groups.[2]

Enrollment

On the basis of administrative data, CBO estimates that about half of Medicaid's 60 million enrollees in 2006 are poor children, and another one-fourth are either the parents of those children or poor pregnant women. The remaining one-fourth of enrollees are either aged, blind, or disabled. (Children and parents who are disabled are included in the latter category.) Additional information about the income or other characteristics of enrollees can be derived from survey data, but it comes with several limitations. Surveys generally exclude people who live in institutions, such as nursing homes—but a large share of nursing home residents are Medicaid beneficiaries. Even after accounting for that fact, surveys tend to underestimate Medicaid's total enrollment. In addition, many surveys measure income on an annual basis, whereas eligibility for Medicaid is generally determined by a person's monthly income, which may fluctuate.[3]

Notwithstanding those caveats, survey data suggest that Medicaid mainly covers people whose income is less than 200 percent of the federal poverty threshold—currently, about $40,000 per year for a family of four. The most recent estimates cover 2004; they indicate that about 54 percent of Medicaid enrollees had a level of family income that was below the poverty threshold; another 29 percent had income that was between 100 percent and 200 percent of that threshold; and 17 percent had higher income. Expressed another way, Medicaid is estimated to cover at least 35 percent of all individuals whose family income falls below the poverty level, about 17 percent of those whose income is between 100 percent and 200 percent of that level, and about 3 percent of the (much larger) group whose income is more than 200 percent of the poverty level.

Although Medicaid is designed primarily to serve poorer individuals and families, many poor people are ineligible for the program. (For example, most poor childless adults do not qualify.) Because eligibility for Medicaid is based partly on income, enrollment in the program by children and families is somewhat cyclical, growing faster when the economy weakens and more slowly when the economy

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2. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005), p. 11.

3. Survey data may also fail to distinguish between enrollment in Medicaid and enrollment in the State Children's Health Insurance Program (described later) or may compare current insurance coverage with income for the prior year. The figures presented here are CBO's calculations based on data from the March 2005 Current Population Survey of the Bureau of the Census.

becomes stronger. At the same time, according to survey data, many people who are eligible for Medicaid do not enroll in the program, even when they lack other health insurance. For instance, one recent estimate indicated that about one-third of the 10 million children identified by surveys as uninsured are eligible for Medicaid.[4]

The gap between eligibility and enrollment may reflect a lack of awareness about Medicaid as well as the effect of stigma commonly associated with welfare-related programs. At the same time, eligible individuals who require medical care may receive Medicaid coverage for their health care services retroactively, so they have some protection against incurring substantial health care costs even if they are not enrolled in the program. The rates at which eligible individuals "take up" coverage also vary with the extent of the benefits that Medicaid will provide. Take-up rates are very high, for example, among Medicare beneficiaries who are also eligible for full benefits under Medicaid, including coverage of nursing home costs. (Those beneficiaries are referred to as dual eligibles.) Take-up rates are much lower for Medicare beneficiaries who qualify only to have Medicaid pay their cost-sharing requirements under Medicare and their Medicare Part B premiums.

Spending for Benefits

Medicaid's spending for benefits may be classified either by the types of enrollees who receive those benefits or by the types of services such spending purchases. As noted earlier, about three-quarters of Medicaid enrollees in 2006 are either poor children, their parents, or poor pregnant women, and per capita costs for those groups are relatively low. By contrast, expenses per enrollee are higher for elderly and disabled beneficiaries, many of whom require long-term care. Although the elderly and disabled constitute about one-quarter of Medicaid's enrollees, they account for about 70 percent of the program's spending for benefits (see Table 1).

Overall, one-third of Medicaid's spending for benefits in 2006 is projected to go toward long-term care, which includes nursing home services, home health care, and other medical and social services for people with chronic disabilities. Acute care costs account for nearly all of the remaining benefit expenditures—one-third of which go to hospitals, one-sixth to prescription drugs, one-sixth to physicians and other practitioners, and one-third to other acute care services.

Most services covered under Medicaid are paid for on a fee-for-service basis, and states generally determine the payment rates for doctors, hospitals, and other providers of health care to the program's beneficiaries. Analyses of Medicaid's fee-for-service reimbursement rates have found them to be lower than those of Medicare and of private-sector insurers. Over the years, a number of states have

4. T.M. Selden, J.L. Hudson, and J.S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.

Table 1.

Distribution of Medicaid Enrollees and Benefit Payments by Eligibility Category, Fiscal Year 2006

	Enrollees		Benefit Payments	
	Number (Millions)	Percentage	Total (Billions of dollars)	Percentage
Aged	5.7	9.6	38.5	22.6
Disabled	9.9	16.5	78.3	45.9
Children	28.4	47.6	31.9	18.7
Adults	15.7	26.3	21.7	12.7
Total	**59.7**	**100.0**	**170.4**	**100.0**

Source: Congressional Budget Office.

claimed higher payments to providers than they actually made and have used the higher federal matching funds that resulted either to help cover the state's share of Medicaid costs or for other purposes. (Such financing arrangements are part of the reason that it is difficult to determine states' Medicaid costs precisely.) In response, the federal government has tightened regulations related to upper limits on payments for some Medicaid services that are based on payment rates in the Medicare program. Other steps the federal government has taken to control Medicaid spending include limiting the amounts that states may pay for certain prescription drugs and requiring that drug manufacturers that wish to serve the Medicaid population provide substantial rebates to the program.

Currently, about one-third of Medicaid beneficiaries are enrolled in managed care plans that accept a capitated payment (a fixed amount per enrollee) for providing most of the program's acute care benefits. Those arrangements are mainly for families and children and generally do not cover long-term care services. Consequently, those capitation payments account for less than 15 percent of Medicaid's total expenditures for benefits. As an alternative to capitation arrangements, many states have adopted primary care case management models, in which enrollees select (or are assigned) a primary care physician or a group practice that is paid an added fee for overseeing and coordinating their care. Even more popular in recent years have been "carve-out" arrangements, in which states contract with organizations to provide a subset of Medicaid benefits, such as dental services or mental health care.

Cost Sharing

Cost-sharing requirements for enrollees in the Medicaid program are also set by the states, subject to federal guidelines. Before passage of the Deficit Reduction Act of 2005 (DRA), states could require nominal cost sharing on services for certain beneficiaries other than children and pregnant women and faced narrow limits on their ability to charge premiums. Medicaid regulations limited cost sharing to

$3 for most services and barred providers from denying services to individuals who did not pay it. As a result, the majority of Medicaid enrollees did not pay any cost sharing.

The DRA gave states the option to increase the level of cost sharing and require the payment of premiums by many Medicaid beneficiaries whose family income is at or above the poverty level. (Exceptions include children whom states are required to cover under Medicaid rules, pregnant women, and individuals living in institutions.) States may require individuals whose family income is between 100 percent and 150 percent of the poverty level to pay up to 10 percent of the cost of their services; individuals with higher income may be charged 20 percent coinsurance. However, total cost sharing and premiums for all Medicaid beneficiaries in a family may not exceed 5 percent of the family's income. Under the DRA, states may also allow providers to deny services for lack of payment and may require enrollees to prepay premiums before they receive benefits. States are also permitted to increase nominal copayments over time at the rate of medical inflation for individuals whose income is below the poverty level.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) offers coverage to uninsured children in families whose income is too high to allow them to qualify for Medicaid but is generally below 200 percent of the poverty level. As with the Medicaid program, states have flexibility in how they administer SCHIP; within broad federal guidelines, they may vary the eligibility thresholds, benefits, cost sharing, and other parameters. The program is structured as a capped entitlement, with federal matching funds available (at a somewhat higher rate than for Medicaid) but subject to an overall annual limit. SCHIP currently covers an estimated 4.3 million children, and federal outlays for the program over the next 10 years are projected to be $52 billion. (Many states have chosen to provide SCHIP coverage through their Medicaid program, but the data presented in this testimony exclude SCHIP and are for Medicaid coverage only.)

Sources of Growth in Medicaid Spending

To understand the main factors that drive Medicaid spending—and how they compare with the forces that affect overall health care spending in the United States—it is useful to examine short- and long-term trends in past spending and in projections of future costs.

Growth of Past Spending

Between 1999 and 2004, federal spending for Medicaid increased by 64 percent, growing from $108 billion to $176 billion. Rising enrollment played a major role in that spending growth: CBO estimates that over the same period, enrollment in Medicaid grew by 36 percent, climbing from 41.9 million to 56.9 million. About seven-eighths of that growth came from increased enrollment of children and

adults. For those two groups, federal spending for benefits per enrollee grew by 25 percent during that five-year period; per capita costs for disabled and elderly enrollees grew by 31 percent. Overall, federal spending for benefits per enrollee grew more slowly—by 21 percent—reflecting the fact that most of the growth in enrollment occurred among groups that have lower per capita health care costs.[5]

The rapid growth of Medicaid spending and enrollment between 1999 and 2004 reflected both the recession that occurred in that period, which increased the number of families eligible for the program, and state-level expansions of coverage and enrollment outreach efforts. Greater state adoption of financing mechanisms to increase federal payments also helped boost spending—particularly in 2001 and 2002, when federal Medicaid costs grew by 11.1 percent and 13.2 percent, respectively. Temporary increases in the federal matching rate during 2003 and 2004 also played a role. CBO estimates that since 2004, enrollment in and spending for the Medicaid program have increased at a much slower rate, reflecting more-rapid economic growth as well as actions by the states to rein in the program's costs.

A longer-term perspective shows that federal spending for Medicaid between 1975 and 2002 grew from about $7 billion to $148 billion, or at an average annual rate of growth of about 12 percent. During that same period, according to the Centers for Medicare and Medicaid Services (CMS), total spending for Medicaid benefits rose from $12 billion to $213 billion—or at an average annual rate of 11.2 percent. (CMS and state agencies jointly administer the Medicaid program.) Note that the latter figures exclude certain Medicaid costs that are not counted as benefits, such as DSH payments and administrative costs, but include reported federal and state payments—which accounts for the difference in the rates of growth of total federal Medicaid costs and total benefit payments for the same period.

Historical data covering Medicaid's spending for benefits may be used to determine the share of cost growth attributable to three factors: increases in the number of beneficiaries who receive services; general inflation in prices; and rising real (inflation-adjusted) costs per recipient. Increases in real costs per recipient reflect a combination of price increases that exceed the rate of general inflation, a rising quantity of services per recipient, and an increase in the intensity, or complexity, of the services provided. If the impact of general price inflation is factored out, the average real rate of growth for total benefit payments from 1975 to 2002 is 7.1 percent (see Table 2).[6] Over that period, about 40 percent of the growth in Medicaid

5. Another reason for the relatively slow growth of overall costs per enrollee is that some states implemented expansions of coverage that provided only a limited set of lower-cost services (for example, family planning). The interaction of rising enrollment and rising federal costs per enrollee accounts for the remainder of the 64 percent increase in federal spending.

6. The count of recipients represents the number of individuals actually using some form of covered health care service from Medicaid during the year; the total number of program enrollees is slightly larger. Comparable data on Medicaid spending and recipients of services by eligibility group are not readily available before 1975 or after 2002. As a result, the remainder of this historical analysis focuses on the span of those years. Spending figures were adjusted for inflation using the GDP price deflator.

Table 2.

Sources of Real Growth in Federal and State Medicaid Spending by Eligibility Group

(2002 dollars)

	1975	2002	Average Growth Rate (Percent)	Share of Total Cost Growth (Percent)
Aged				
Number of Recipients (Millions)	3.6	3.9	0.3	0.6
Cost per Recipient (Dollars)	3,302	13,358	5.3	22.7
Total Cost (Millions of dollars)	11,937	51,924	5.6	23.3
Disabled				
Number of Recipients (Millions)	2.5	7.4	4.2	21.4
Cost per Recipient (Dollars)	3,496	12,475	4.8	27.4
Total Cost (Millions of dollars)	8,615	92,414	9.2	48.8
Children				
Number of Recipients (Millions)	9.6	23.2	3.3	8.5
Cost per Recipient (Dollars)	624	1,545	3.4	8.9
Total Cost (Millions of dollars)	5,988	35,890	6.9	17.4
Adults				
Number of Recipients (Millions)	4.5	11.3	3.4	7.2
Cost per Recipient (Dollars)	1,247	2,100	1.9	3.3
Total Cost (Millions of dollars)	5,648	23,635	5.4	10.5
All Eligibility Groups				
Number of Recipients (Millions)	20.2	45.8	3.1	37.7
Cost per Recipient (Dollars)	1,593	4,453	3.9	62.3
Total Cost (Millions of dollars)	32,188	203,863	7.1	100.0

Source: Congressional Budget Office based on data from Centers for Medicare and Medicaid Services, *Health Care Financing Review Statistical Supplement 2004* (April 2006).

Note: Figures exclude a small share of recipients whose eligibility is categorized as "other/unknown" and spending for those recipients. Dollar amounts were adjusted for inflation using the GDP price deflator.

spending resulted from a rising number of recipients, and about 60 percent was due to real increases in treatment costs per recipient. (Thus, the period from 1999 to 2004, in which enrollment growth was so rapid as to outweigh growth in costs per enrollee, is an exception to the general trend.)

Spending Growth by Eligibility Group. The historical data on Medicaid spending reveal significant differences in the levels and sources of real spending growth among the program's four basic eligibility groups: children, adults, aged people, and disabled individuals. Total spending has grown most slowly—by about 5.5 percent per year, in real terms—for adults and for the aged, but for different rea-

sons. Among adults, costs per recipient have risen relatively slowly (although that trend could also indicate that adults who have recently enrolled in Medicaid have lower average health care costs than those who met the earlier eligibility criteria). By contrast, the number of elderly beneficiaries who receive some type of Medicaid-covered service has scarcely grown over the past three decades; virtually all of the increase in spending for that group can thus be attributed to rising costs per recipient. Spending for children has grown more rapidly, and that growth is due about equally to an increase in the number of recipients and an increase in costs per recipient. Among disabled beneficiaries, however, the number of recipients has grown at an even faster rate, averaging 4.2 percent per year since 1975. Costs per disabled recipient have grown even more rapidly—at an average real rate of 4.8 percent per year.

Another way to analyze the rise in spending in the Medicaid program is to consider the share of the growth of real benefit spending accounted for by increases in the number of recipients and in costs per recipient for each eligibility group. Even though enrollment of children has grown dramatically—partly reflecting substantial expansions of eligibility—their rising participation accounts for less than 10 percent of the total cost growth in the program since 1975. Of that growth, the largest share (fully half) is attributable to disabled beneficiaries. Because they have been more expensive to treat than nondisabled adults and children—and about as expensive, on a per recipient basis, as elderly Medicaid enrollees—their rising numbers and growing costs per recipient have each contributed substantially to the increases in Medicaid spending. Higher costs among the elderly also accounted for a large share of the program's total cost growth, despite the small increases for that group in the number of service recipients. Spending for the elderly represented nearly 40 percent of total costs in 1975, so their rapidly rising costs per recipient have had an outsized impact on the program's finances.

Spending Growth by Service Category. Data from CMS show that during the 1975-2002 period, real spending growth also varied considerably among the different types of health care services that Medicaid purchases (see Table 3). Growth of total state and federal payments to hospitals (including DSH payments) was relatively slow—6.7 percent per year in real terms, compared with an overall rate of 7.2 percent for payments to providers. Growth of payments to physicians and other health care professionals was also slower than overall Medicaid spending—but faster than that of the economy as a whole. Real spending growth has been most rapid for prescription drugs, causing their share of total Medicaid payments to nearly double. Even so, such spending accounted for about one-eighth of total state and federal Medicaid costs by the end of the period.

Projected Growth of Spending

CBO projects that under current law, federal spending for Medicaid benefits will double in nominal terms over the next 10 years, increasing from $179 billion in fiscal year 2007 to $361 billion in 2016, for an average annual rate of growth of

Table 3.

Real Medicaid Spending by Type of Service

(Millions of 2002 dollars)

	1975		2002		Average Growth Rate (Percent)
	Total Spending	Percentage	Total Spending	Percentage	
Hospital[a]	14,238	40	83,014	36	6.7
Physician, Dental, and Other Professional	6,254	18	30,431	13	6.0
Prescription Drugs	2,386	7	28,650	12	9.6
Home Health, Nursing Home, and Other	12,291	35	90,167	39	7.7
All Services	**35,169**	**100**	**232,262**	**100**	**7.2**

Source: Congressional Budget Office calculations based on National Health Expenditure data from the Centers for Medicare and Medicaid Services.

Note: Data include both federal and state spending. Dollar amounts cover calendar years and were adjusted for inflation using the GDP price deflator.

a. Includes disproportionate share, or DSH, payments (which is the main reason that totals for all services here do not match those for "All Eligibility Groups" in Table 2).

8.1 percent (see Table 4). Key factors underlying that increase in spending include the following:

- Enrollment is projected to grow by about 2.5 percent per year among the aged and disabled, reflecting somewhat faster growth of the overall elderly population as well as the impact of waiver programs to provide community-based long-term care services to the disabled. On average, enrollment of children and adults is not expected to increase substantially under current law both because of slow growth in the eligible population and because states are not likely to further expand eligibility for those groups.

- Projected rates of cost growth per enrollee are comparable among eligibility groups with the exception of elderly people; that group is expected to see a somewhat slower rise in spending, in part because their prescription drug costs are now covered under Medicare. Even so, costs per enrollee in the Medicaid program overall will grow somewhat more quickly (by 7.1 percent per year, on average) than per capita costs for any single eligibility group, reflecting the expectation of faster growth in enrollment for the higher-cost groups. (If those figures were adjusted for general inflation to make them more comparable with the data on past spending growth presented earlier, the projected growth rates would be about 2.5 percentage points lower.)

Table 4.

Projected Federal Benefit Spending, Enrollment, and Costs per Enrollee for Medicaid, by Eligibility Category, Fiscal Years 2006 to 2016

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average Nominal Growth Rate, 2007-2016 (Percent)
						Federal Benefit Payments (Billions of dollars)						
Aged	38.5	39.1	41.9	44.9	48.2	51.9	55.8	60.4	65.4	70.7	76.7	7.8
Disabled	78.3	83.2	91.5	100.1	109.0	118.5	129.2	140.4	152.6	165.8	180.3	9.0
Children	31.9	34.1	36.7	39.7	42.4	45.4	48.6	51.9	55.5	59.4	63.7	7.2
Adults	21.7	22.9	24.2	25.9	27.6	29.4	31.3	33.3	35.5	37.8	40.3	6.5
Total	170.4	179.3	194.3	210.5	227.2	245.2	264.9	286.0	309.0	333.8	361.0	8.1
Memorandum:												
Total Federal Medicaid Spending	189.8	199.3	215.3	232.6	250.3	269.5	290.4	312.8	337.0	363.3	391.9	7.8
						Enrollment (Millions of people)						
Aged	5.7	6.0	6.2	6.4	6.5	6.7	6.8	7.0	7.2	7.4	7.5	2.6
Disabled	9.9	10.3	10.7	11.1	11.3	11.5	11.8	12.0	12.3	12.5	12.8	2.4
Children	28.4	28.7	28.6	28.8	28.8	29.0	29.0	29.1	29.2	29.3	29.4	0.3
Adults	15.7	15.6	15.7	15.8	15.9	16.0	16.0	16.1	16.2	16.2	16.3	0.5
Total	59.7	60.6	61.2	62.1	62.6	63.2	63.7	64.3	64.8	65.4	66.0	1.0
						Average Cost per Enrollee (Dollars)[a]						
Aged	6,710	6,510	6,710	7,000	7,370	7,770	8,160	8,620	9,100	9,620	10,180	5.1
Disabled	7,940	8,090	8,530	9,030	9,630	10,270	10,970	11,680	12,440	13,240	14,110	6.4
Children	1,120	1,190	1,280	1,380	1,470	1,570	1,670	1,780	1,900	2,030	2,170	6.9
Adults	1,380	1,470	1,540	1,640	1,730	1,840	1,950	2,070	2,190	2,330	2,480	6.0
Overall Average	2,850	2,960	3,170	3,390	3,630	3,880	4,160	4,450	4,770	5,110	5,470	7.1

Source: Congressional Budget Office.

a. Costs are rounded to the nearest 10 dollars.

Table 5.

Projected Spending for Medicaid, Medicare, and Social Security as a Share of Gross Domestic Product

(Percent)

		2050		
	2006	Lower Spending Path	Intermediate Spending Path	Higher Spending Path
Medicaid[a]	1.5	1.9	4.0	5.9
Medicare	3.0	5.1	8.6	16.0
Social Security	4.2	6.3	6.4	6.6
Total	**8.7**	**13.3**	**19.0**	**28.5**

Source: Congressional Budget Office based on supplemental data from its December 2005 report *The Long-Term Budget Outlook*.

Notes: Projections cover total spending for benefits under current law.

a. Projections incorporate the assumption that enrollment in the program will grow at the same rate as that of the general population.

- As for spending by category of service, payments to hospitals and physicians and for institutional care—which currently account for about half of all benefit payments—are expected to grow by an average of 6.5 percent per year. Payments for prescription drugs and noninstitutional long-term care—which currently account for about one-fifth of spending on benefits—are projected to rise at an average annual rate of 11.2 percent. (Adjusting for general inflation would reduce those rates by about 2.5 percentage points as well.)

Looking beyond the 10-year budget horizon, CBO has projected federal spending for Medicaid and the other major benefit programs through 2050 under various assumptions (see Table 5).[7] Projections for Medicaid all reflect the assumption that enrollment in the program will grow at the same rate as that for the population as a whole. (That assumption is consistent with CBO's 10-year estimates of spending for Medicaid.) In addition, CBO's set of intermediate spending projections incorporate the assumption that health care costs per enrollee will grow more slowly in the future than they have in the past, with the growth rate ultimately reaching a level that is 1 percentage point faster than the growth of GDP per capita.

That assumption presumes a substantial decrease in the growth of health care costs per capita compared with the historical growth rates seen in federal health programs and in the U.S. health sector as a whole. Over the past several decades, the rise of health care costs per capita has typically exceeded the growth of GDP per capita by more than 2 percentage points. (That gap has been smaller in some recent

7. For a more detailed discussion, see Congressional Budget Office, *The Long-Term Budget Outlook* (December 2005).

periods, reflecting in part the combined impact of faster economic growth and greater use of managed care plans in the private health insurance market.) In effect, then, CBO's intermediate projection incorporates the assumption that forces within the health care sector will slow the overall rate of cost growth in the United States and that per capita spending growth in the Medicaid program will generally follow the same trend. There is considerable uncertainty about the likely path of per capita health care costs, however, which is represented by the range of CBO's long-term projections. An additional source of uncertainty surrounding projections for Medicaid is whether states will take more aggressive steps to constrain spending (such as limiting coverage of optional populations or benefits) as costs for the program become a larger and larger share of their budgets.

Even under the assumption that the growth of health care costs will moderate, spending for Medicaid by the federal government alone is projected to account for 4 percent of the economy by 2050, as compared with its current share of 1.5 percent. If, instead, Medicaid's spending per enrollee grew at the historical rate of U.S. health care costs overall—about 2.5 percentage points faster than GDP per capita—federal costs for the program would reach 5.9 percent of GDP in 2050, or nearly the same share as that expected for Social Security. Whichever path Medicaid's spending takes, its future growth will coincide with rising costs for Social Security and, in particular, for Medicare. Those increases—driven by both a burgeoning elderly population and increasing costs per Medicare beneficiary—are projected to put significant pressure on the federal budget and the U.S. economy. Total spending for current-law benefits under all three programs would reach nearly 20 percent of GDP in 2050, according to CBO's intermediate projections.

The impending retirement of members of the baby-boom generation and their increasing life expectancy play important roles in those projections of spending, but uncertainty also exists about the impact that those demographic forces will have on enrollment in Medicaid and on the program's finances. In the near term at least (that is, the next 10 years), newly enrolled seniors will be relatively young and will tend to have lower health care costs than existing elderly enrollees have. Over time, though, the baby boomers' costs for acute health care and their rates of functional impairment are sure to rise. The former will be financed largely by Medicare, but rising costs for long-term care in general and nursing home care in particular will fall primarily on Medicaid.

Yet future rates of nursing home use will be affected by several competing forces. While the elderly population will increase substantially, some studies predict that disability rates at any given age will continue to decline (though others maintain that they will increase). The share of the population ages 85 and older is expected to triple by 2050, and that group has the highest rates of nursing home use. However, the number of nursing home residents (both overall and in the Medicaid program) has grown more slowly than the elderly population as a whole, particularly in recent years. Thus, it is difficult to determine whether the impact of the baby

boomers' retirement on Medicaid's finances will merely be delayed—until they reach more advanced ages—or will ultimately remain limited.

Growth of U.S. Health Care Spending

The factors that drive the growth of costs in the Medicaid program and the challenges that the program faces in controlling those costs are similar in many ways to those for the U.S. health care system as a whole. In calendar year 2004, the United States spent about $1.9 trillion for health care, an amount nearly five times as great in real terms as was spent in calendar year 1975. Real spending per capita increased from about $1,700 in 1975 to about $6,300 in 2004, an average annual rate of real growth of 4.5 percent. The economy as a whole grew over that period as well but not as quickly, with the result that health care spending as a percentage of GDP doubled—rising from about 8 percent in 1975 to about 16 percent in 2004. The mid-1990s saw a brief slowdown in real spending growth per capita, but higher rates of growth have returned in more recent years: from 2000 to 2004, real health care spending per capita grew at an average annual rate of 5 percent, which is similar to its long-term historical average.

Technology and Rising Health Care Costs

Most analysts agree that the bulk of the growth in overall health care spending is associated with the increasing use of new medical technologies, or as one analyst has described it, "the increased capabilities of medicine."[8] Advances in medical technology in recent decades have made available a wealth of new therapies. Some of those advances have made it possible to treat previously untreatable conditions, potentially yielding substantial gains in the quality of people's lives but creating new categories of spending in the process. Other advances have improved medical outcomes relative to older modes of treatment—providing greater benefits but often at an additional cost. In some cases, the cost of a particular medical service may remain the same over time or even diminish; even in those cases, however, higher overall spending may still result as clinical practice patterns evolve and the service is used with greater frequency among a broader range of patients. For example, one influential study found that the price of specific treatments for a heart attack rose at about the rate of general inflation, but the greater use of more-expensive bypass operations caused total spending for cardiac care to grow rapidly.[9]

In some cases, advances in medical technology may lead to reductions in spending. Vaccinations, for example, offer the potential for savings on subsequent treatment costs, and certain types of preventive medical care may help some patients

8. Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, vol. 6, no. 2 (Summer 1992), pp. 3-21.

9. David M. Cutler and others, "Are Medical Prices Declining? Evidence from Heart Attack Treatments," *Quarterly Journal of Economics*, vol. 113, no. 4 (November 1998), pp. 991-1024.

avoid costly hospitalizations. Overall, however, examples of new therapies for which long-term savings have been clearly demonstrated are few. As with preventive care, new prescription drugs may help some patients avoid more expensive treatments—but they may also generate new spending for previously untreated cases that would not have become more serious. Improvements in medical care that decrease mortality by helping patients avoid or survive acute health problems may ultimately increase overall spending for health care as those (surviving) patients live to use additional health care services throughout their old age.

Adoption of new technology is not unique to the health care sector, of course, but in other sectors of the economy, businesses and consumers bear the cost of such purchases more directly and will thus be inclined to spend money on them only if the benefits exceed the costs. In the health care arena, two factors may combine to produce a different result: first, payments made by insurers typically buffer patients from the full cost of the medical services they use; and second, the complexity of medical practice forces patients to rely on the judgment of providers who, depending on the reimbursement system being used, may have an incentive to provide more care (under a fee-for-service arrangement) or less care (under capitation). In principle, the health plans that provide insurance coverage have incentives to balance costs and benefits, but views differ about whether and to what extent that balancing occurs in practice. Thus, some uncertainty remains about the value derived from new medical technologies, particularly as they are applied to more and more cases in which the additional benefits may be marginal.

Other Factors That Contribute to the Growth of Health Care Costs

Although the diffusion of new medical technologies is generally considered the primary impetus for the long-term increase in overall spending for medical care, other factors certainly contribute to it as well. One source of cost growth has been the aging of the population. Among adults, average medical spending generally increases with age, so as the share of the population that is elderly grows, health care spending per capita will rise. Over the past half century, however, aging has played a relatively minor role in the very large increases in overall spending that have occurred—accounting for only 2 percent of that growth, by some estimates.[10] The coming retirement of the baby boomers will further increase the elderly's population share and thus have a larger impact than past aging trends have had. Even so, the growth of medical costs per person is likely to remain the predominant reason that health care spending for the country as a whole continues to climb.

Other factors that are contributing to the growth of overall health care spending include real increases in personal income over time and the deepening of health insurance coverage over recent decades. Because medical care is a desirable service,

10. See Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (December 2000), available at www.cms.hhs.gov/ReportsTrustFunds/downloads/TechnicalPanelReport2000.pdf.

demand for it tends to rise as real incomes move upward. At the same time, from the consumer's perspective, health insurance coverage reduces the cost of care, which leads consumers to demand increasing quantities of services. Although the estimated fraction of Americans who have health insurance has not changed dramatically during the past 20 years, private health insurance has covered an expanding share of all private health care costs; such coverage has thus deepened rather than broadened. Even so, the best estimates of the effects of income and insurance coverage on health care costs indicate that those factors, too, fail to explain much of the surge in spending in recent decades.

Impact of Factors on Medicaid

Rising real incomes and the spread of insurance may not seem relevant to an analysis of Medicaid's cost growth, since the program's rules mean that those dimensions do not change substantially for enrollees. Indeed, broad increases in real incomes could be expected to reduce the share of the population that is eligible for Medicaid (because poverty thresholds are indexed to general inflation). Those factors are relevant, though, because as capabilities and standards for the delivery of health care overall increase, they tend to be incorporated into Medicaid as well. In part, that process reflects choices made by program administrators about what procedures to cover, and in part it reflects the tendency of physicians to provide a comparable level of care to all of their patients, regardless of their patients' source of insurance. For the same reason—but perhaps even more directly—new technologies for providing acute medical care are likely to become broadly available to both Medicaid and non-Medicaid populations alike. Thus, the program's spending for such things as hospital care, physician services, medical equipment, prescription drugs, and laboratory tests is driven by the same changes in technology that affect the health care system as a whole.

Somewhat less clear are the factors that are boosting costs for long-term care services. Over the past 30 years, spending for nursing homes that is financed both by the private sector and the Medicaid program has grown faster than the economy as a whole, even though the number of nursing home residents has not kept pace with an expanding elderly population. New technology seems a less likely reason for the increases in costs per resident, although advances in acute care could be extending the lives of some people with serious medical conditions and thus raising the average level of sickness of nursing home residents—making them more expensive to serve. A more certain consideration stems from the fact that such care is labor intensive; average nursing home costs would thus be expected to grow along with average increases in wages and other compensation. Rising incomes and other changes in society may also have led to some substitution of formal long-term care for informal care; however, CBO estimates that informal care still constitutes the largest single source of total long-term care financing. Because of Medicaid's large role in the nursing home sector, it is difficult to determine whether Medicaid spending is tracking private-sector trends or shaping them.

Interactions Between Medicaid and Private Insurance

Medicaid covers many people who otherwise would have considerable difficulty in obtaining private health insurance. For the program's current enrollees, problems of access to such coverage may arise for a number of reasons: because they are not part of the labor force or are not offered employer-sponsored insurance (the primary source of health insurance coverage in the United States); because their health problems make coverage very expensive; or simply because they have low incomes and resources. For some enrollees, however, Medicaid appears to be substituting for certain forms of private insurance, a phenomenon known as crowd-out. Concerns about crowd-out by Medicaid are greatest with respect to children and adults whose family income is above the poverty line and who might otherwise have purchased employer-sponsored insurance, and elderly enrollees who might otherwise have bought private insurance for long-term care—or saved more to cover the costs of such care—when they were younger. To the extent that crowd-out occurs, policymakers may face difficult trade-offs between providing insurance coverage on the one hand and substituting public funds for private funds on the other.

Employer-Sponsored Health Insurance

Several well-designed economic analyses have found that expansions of public insurance for low-income children and families have generated some offsetting reductions in private employer-sponsored insurance coverage for those groups. As a result, the net decrease in the number of uninsured individuals as a result of expansions of public coverage has probably been smaller than the increase in the public program's enrollment. For example, one study examined expansions of Medicaid coverage in the late 1980s and early 1990s and concluded that about 50 percent of the increase in enrollment that occurred was offset by reductions in private health insurance coverage. Other studies, however, have reported lower estimates of crowd-out. More recently, an analysis of SCHIP's implementation found crowd-out rates of 18 percent to 50 percent (once the researchers addressed problems in the reporting of insurance coverage). Lower rates for SCHIP than for Medicaid could reflect the greater efforts that were made during SCHIP's implementation to discourage substitution of public for private coverage.[11]

The extent of and mechanisms for the crowding out of employer-sponsored insurance may vary on several dimensions. Concerns about the phenomenon tend to increase as the income threshold for public programs rises, because a larger share of people who have higher incomes also have private coverage. For example, survey data on insurance coverage from 2005 indicated that for individuals whose family

11. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, vol. 111, no. 2 (May 1996), pp. 391-430; and Anthony T. LoSasso and Thomas C. Buchmueller, *The Effect of the State Children's Health Insurance Program on Health Insurance Coverage*, Working Paper No. 9405 (Cambridge, Mass.: National Bureau of Economic Research, December 2002).

income was between 100 percent and 150 percent of the poverty line, 39 percent were privately insured; that share rose to 54 percent, however, for those whose income was between 150 percent and 200 percent of the poverty threshold and to 65 percent for those whose income was between 200 percent and 250 percent. Moreover, such crowding out may occur in two ways: either employees who are eligible for coverage decline to take it, or employers decide not to offer insurance. (If, instead, employers decided to increase employees' contributions to health insurance premiums, that increase could also lead employees to decline coverage.)

More recently, related concerns have been raised about firms that employ lower-wage workers and the number of those employees or their dependents who have enrolled in Medicaid. It is difficult to gauge the prevalence of that phenomenon or determine the factors that might be causing it to increase. The share of workers who have employer-sponsored health insurance has decreased somewhat since 2000, but according to surveys of employers, that development largely reflects a decline in the percentage of smaller firms who are offering insurance; coverage rates at larger firms have fluctuated over time but were comparable in 2000 and 2005.[12] There is also some evidence that in recent years, employment has shifted somewhat to smaller firms and to industries that are less likely to offer coverage. Analyses that focused specifically on low-wage workers have found that, relative to higher-wage workers, they are less likely to be offered health coverage, are less likely to take it up when it is offered, and are more likely to be enrolled in Medicaid. The factors underlying any recent trends in coverage for low-wage workers, however, are less clear. Also difficult to determine is the extent to which recent state-level expansions of Medicaid have been either a cause of or a response to those declines in employer-based coverage—although some crowd-out seems likely to have occurred, given the large increases in Medicaid's enrollment.

Long-Term Care Insurance

Medicaid generally serves people with very low incomes, but it also provides assistance to impaired people with higher incomes who exhaust all other sources of financing for their health care—in particular, for their nursing home care. That care can deplete private resources quickly: costs for a semiprivate room average more than $50,000 per year, and stays in nursing homes often last longer than a year. According to a 1996 study, about one-third of nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances, and nearly one-half of existing residents had similarly

12. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (Washington, D.C., September 2005). Since 2000, employees' contributions to health insurance premiums have risen sharply in dollar terms, but the average share of premiums paid directly by workers has remained relatively constant both for single and family coverage, and take-up rates have not varied significantly.

qualified for Medicaid coverage.[13] CBO estimates that those proportions remain similar for the current nursing home population.

At least in principle, many current nursing home residents would not have become Medicaid beneficiaries (or would have enrolled at a later point) if they had purchased a private long-term care (LTC) insurance policy. Such policies typically promise to pay up to a specified amount per day for nursing home and home health care services for policyholders who develop chronic impairments. (Claims are usually subject to an overall limit on the number of years or the total expenses that will be covered.) LTC insurance is a relatively new product, however, and currently finances less than 5 percent of those services, in CBO's estimation. Depending on the terms of an LTC insurance policy, annual premiums may average $1,000 to $2,000 if the policy is purchased at age 65; premiums increase rapidly for those who wait longer to purchase coverage. (That increase reflects both the higher risk of needing long-term care as a person ages and the fewer number of years in which premiums are likely to be paid.)

Many poorer seniors would have difficulty paying for private LTC insurance, even if Medicaid coverage for long-term care was not available. For those with higher incomes, however, the availability of coverage through Medicaid after they exhaust their own resources discourages them from purchasing or maintaining such a policy. People who buy private LTC insurance substantially reduce the probability that they will ever qualify for Medicaid benefits. In that sense, as people prepare financially for their long-term care needs, they forgo the value of the benefits they might otherwise have received—which effectively raises the relative cost of purchasing a private insurance policy.

Medicaid is not a perfect substitute for private LTC insurance, but the drawbacks to Medicaid's coverage are balanced by several features that are advantageous.

- One drawback is that, as a means-tested program, Medicaid requires eligible applicants to rely on out-of-pocket spending until they use up nearly all of their savings and all but a small share of their income. (Even after exhausting their assets, nursing home residents may have income from other sources, such as a private pension or Social Security.) Private LTC insurance, by contrast, may allow policyholders to protect their resources.

- Another downside to Medicaid is that it generally pays lower fees for services than private insurers pay, so its beneficiaries may not receive the same quality of care as private policyholders or have access to the same facilities.

13. Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996).

- One major advantage of Medicaid is that from the beneficiary's perspective, its coverage is free—whereas private LTC insurance requires premium payments.

- Another attraction of Medicaid is that it covers most LTC services with no explicit cap on their costs. Private LTC insurance generally provides a specified monetary benefit to pay for care—and in return for a higher premium also includes an adjustment for inflation. But it does not guarantee that the payment will be sufficient to cover the costs of that care if daily charges rise faster than the policy's specified amount or if the policyholder's stay in a nursing home extends for many years.

Some people who are planning for their long-term care needs and considering the purchase of a private insurance policy may thus find Medicaid's coverage a more attractive option. Indeed, one recent study found that if people at various income levels took Medicaid's provisions into account in their financial planning, those provisions would constitute a substantial deterrent to their purchasing private insurance.[14] At the same time, a recent survey of individuals ages 45 and older found that many of them mistakenly believed that Medicare or their medigap supplemental insurance policy would pay for extended nursing home care. (Medicare will cover nursing home care for a specified period following a hospital admission; medigap plans will cover only the cost sharing for that care.) At a minimum, that finding suggests that if Medicaid's coverage rules were to change, it would take some time for individuals to adjust their financial planning to take those changes into account.

One option explored by several states in recent years to address the disincentives that Medicaid creates has been to establish LTC "partnership" programs. Under such programs, enrollees who purchase LTC insurance but exhaust that coverage are allowed to protect a corresponding amount of their assets and still qualify for Medicaid. That approach could be advantageous for individuals; however, it might also increase Medicaid's spending for long-term care. Partnership policyholders would generate more Medicaid expenditures than would holders of conventional LTC policies—because partnership coverage would allow its policyholders to qualify for Medicaid without exhausting all of their assets. The effect on Medicaid's expenditures for partnership participants who would otherwise not have purchased private LTC insurance, as well as the extent of that response, is more difficult to determine.[15]

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14. Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market,* Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

15. For additional discussion and analysis of long-term care financing issues, see Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004).

Private Saving for Long-Term Care Costs

As an alternative to purchasing LTC insurance (which has other drawbacks), individuals could "self-insure" by saving more when they are younger to cover their own expenses for long-term care in retirement. However, because Medicaid requires enrollees to use up nearly all of their assets and income before they are eligible for coverage, its provisions also tend to discourage such saving.[16] In the event of a long nursing home stay, the fewer assets that an individual has, the quicker he or she may qualify for Medicaid coverage.

The program's requirements also create incentives for people to hide or transfer their assets before applying for the program (and also to use up their funds more quickly in paying for care). Although applicants face penalties for transferring assets at less than their fair market value, individuals have been able to transfer their assets in a variety of ways that reduce or eliminate any penalty. In addition, some assets have not been considered. For example, until the DRA was enacted, all equity held by homeowners had been excluded in determining a person's eligibility for Medicaid. However, the DRA has made it more difficult to transfer assets without incurring a penalty and in most cases has capped the amount of home equity enrollees may have.

At the same time, uncertainty exists about the extent to which individuals engage in such Medicaid "estate planning," and the available data indicate that many seniors who are likely to need nursing home care and qualify for Medicaid have relatively few assets. There are also some indications that those who have more chronic disabilities enter retirement with fewer assets. But as with LTC insurance, changes in Medicaid's rules could over the longer term encourage individuals who had greater resources to rely more heavily on private funding for their long-term care.

Recent Changes in the Medicaid Program

A number of changes to Medicaid that have been enacted in recent years affect the program's level of spending. Such changes include, in particular, key provisions of the Medicare Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005. (In addition, the states are pursuing a wide variety of initiatives to curb spending.)

The main provision of the MMA that affects Medicaid costs was the creation of a prescription drug benefit within Medicare. As of January 2006, beneficiaries entitled to full coverage under both programs—about 6.2 million individuals—receive drug coverage through Medicare rather than Medicaid. That change substantially reduces federal and state spending for Medicaid; however, the states' drop in costs

16. Lara Gardner and Donna Gilleskie, *The Effects of State Medicaid Policies on the Dynamic Savings Patterns of the Elderly*, Working Paper No. 12208 (Cambridge, Mass.: National Bureau of Economic Research, April 2006).

is less than it might have been because they are required to make payments to the federal government to cover a portion of the estimated costs they would have incurred if they had continued to provide prescription drug benefits to those dually eligible enrollees. States must pay 90 percent of those estimated costs in 2006; that share gradually declines to 75 percent by 2015, where it will remain. Once the phase-down of the states' share is complete, their payments will depend on the number of dual eligibles they have enrolled and the growth of per capita drug costs for the Medicare population as a whole. Although those payments are not counted as costs under Medicaid, they will continue to affect states' fiscal positions.

More recently, the DRA made several substantial changes to Medicaid. CBO has estimated that those changes will:

- Reduce prescription drug costs, primarily by limiting payments to pharmacies for multiple-source drugs (those that have a generic equivalent available);
- Reduce payments for nursing home care by increasing the penalties imposed on individuals who transfer assets for less than their fair market value in order to qualify for nursing home care and by making individuals who have a substantial amount of home equity ineligible for Medicaid's nursing home benefits;
- Reduce Medicaid costs by giving states greater flexibility to impose cost-sharing requirements and premiums and by allowing states to restrict benefits for certain enrollees; and
- Reduce federal matching payments by restricting states' ability to use revenues from taxes on health care providers to finance their share of Medicaid's costs and by limiting the program's coverage of case management services.[17]

CBO estimated that collectively, those provisions would reduce federal Medicaid spending by $38 billion over the 2006-2015 period.

Other provisions of the DRA will increase the program's spending over that period by about $10 billion, in CBO's estimation. Those provisions include greater coverage of certain disabled children, expanded access to home and community-based services, and a "Money-Follows-the-Person" demonstration project that will increase federal payments under Medicaid for certain services after an enrollee leaves a nursing home. Overall, CBO estimated, the DRA's Medicaid provisions will reduce federal outlays by $28 billion over 10 years.[18]

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17. Congressional Budget Office, "S. 1932, Deficit Reduction Act of 2005: Conference agreement, as amended and passed by the Senate on December 21, 2005" (CBO cost estimate, January 27, 2006), available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

18. In addition to the provisions described here, the DRA contained other subtitles affecting Medicaid and SCHIP, including $2 billion in spending for health care costs related to Hurricane Katrina.

CBO will continue to closely monitor the implementation of those provisions, but it is too early to tell how their actual effects will compare with earlier estimates. Moreover, some provisions have not yet taken effect, and others are in the early stages of implementation. For example, CMS recently released its regulations governing the flexibility that the states have to require cost sharing and premium payments by certain Medicaid beneficiaries. It is worth noting that, as challenging as it may have been to enact those measures, the estimated net savings constitute 1 percent of overall Medicaid spending during the next 10 years.

Broad Options for Controlling Medicaid Spending

Although the states have wide latitude to determine the scope of the Medicaid program, the federal government has several avenues by which it might reduce the growth of Medicaid's spending. Yet all of them involve difficult trade-offs. One broad option would be for the federal government to reduce its contribution to the program. Alternatively, it could restrict mandatory benefits and eligibility groups and limit the alternatives available to the states for providing coverage beyond the minimum levels. The federal government could also shift some costs to beneficiaries by requiring greater cost sharing or by making the standards for receiving long-term care services more rigorous. Finally, it could try to encourage greater use of lower-cost services (although finding a mechanism that would accomplish that goal and still yield substantial budgetary savings might prove challenging).

Other options that could be considered might have only a limited potential to generate savings for Medicaid, and some proposals to restructure the program could raise federal costs—primarily by shifting expenditures that are now borne by other payers to the federal budget. The option of reducing Medicaid's costs by lowering payments to providers is constrained by the need to get hospitals, physicians, and managed care plans to participate in the program voluntarily. Reductions below the currently scheduled rates, which are already considered low, could lead providers to refuse to accept Medicaid patients and so limit enrollees' access to care. (In any event, most rates for payments to providers are currently set by state administrators.) Alternatively, rearranging responsibilities within the Medicaid program so that states paid all of the costs for children and adults and the federal government paid all of the costs for elderly and disabled individuals would increase federal spending significantly—because the federal government would assume responsibility for the program's most expensive enrollees.

Reduce the Federal Contribution

The amount that the federal government contributes to each state's Medicaid program is set by a formula related to the per capita income in a state. Federal matching rates are thus higher for poorer states, but under current law, no state receives less than a 50 percent match. The federal match could be reduced either through an across-the-board cut or by reducing the minimum rate, which applies to 12 states in fiscal year 2006. (A related option would be to limit states' actions that in-

creased federal contributions and thereby raised the effective federal matching rate. However, in light of the DRA's recently enacted provisions as well as regulatory efforts to prohibit such actions, it is difficult to determine the potential for savings from further legislation in that area.)

Alternatively, some or all of the federal contribution could be converted into a block grant. In order for that approach to reduce federal spending, the government would have to set a limit on the grant that was below the amount it would have otherwise expected to spend (or it could develop a formula for determining the grant's size that would effectively set such a limit). A similar approach would be to make Medicaid a capped entitlement program, like SCHIP. Federal payments would still match states' expenditures, but federal funds would be cut off when the program's specified annual allotment was exhausted.

The impact of reducing federal contributions to Medicaid would depend to a great extent on the mechanism used for setting and updating the size of the federal block grant, contribution cap, or matching rate. Converting part or all of the program into a block grant or capped entitlement would make the federal government's Medicaid spending more predictable. With a capped entitlement, states would still be encouraged to use the whole federal allotment but beyond that point would have stronger incentives to limit the program's spending—because they would keep all of the resulting savings and not just a portion of them. Depending on the stringency of the federal contribution's limit, that approach would also lessen or eliminate states' motivation to employ funding strategies that sought to maximize federal assistance. With a block grant, states would have the strongest incentives to control overall spending, but by the same token, the federal government might not share in those savings.

Reducing the federal matching rate would also shift a greater burden to the states initially, but because states' expenditures would continue to be matched, that approach would still automatically adjust federal payments as the total cost of serving the Medicaid population rose or fell. If only the minimum matching rate (the one assigned to the most affluent states) was reduced, federal savings would be smaller. In that case, however, the states that bore the burden of the reduction would be those whose residents had the highest incomes.

Opponents to those sorts of options argue that reductions in the federal matching rate or conversion of federal payments to block grants will cause some states to cut needy individuals from their Medicaid rolls or to limit (or eliminate entirely) Medicaid's coverage of important health benefits. Depending on the groups that were affected, some of those individuals might be able to afford private insurance coverage; many would probably end up uninsured. In addition, states with balanced-budget requirements might also find it more difficult to respond flexibly to cyclical fluctuations in the number of Medicaid enrollees or to other sudden changes in the program's costs.

Reduce Mandatory Benefits or Restrict Coverage

Rather than reducing its contribution to the program and letting the states decide how to respond, the federal government could directly reduce the program's mandatory benefits or restrict the groups that could be covered and the additional services that states could choose to offer. Those changes might involve the levels of income or assets needed for eligibility, or they could focus on other program criteria, such as the standards for determining disability. The federal government could also stop granting waivers of the Medicaid statute, which permit states to extend coverage to new populations, generally at additional federal expense.

Reductions in benefits or coverage would have an adverse impact on enrollees who would otherwise receive those services through Medicaid, but the nature and extent of that impact—and the magnitude of the budgetary savings—would depend on the services or eligibility groups involved. Although evidence suggests that expansions of Medicaid coverage for children and families have crowded out some purchases of employer-sponsored insurance, particularly for individuals with higher levels of income, many of those enrollees would probably end up without health insurance if they could not enroll in Medicaid. Depending on their income, those enrollees could also find it difficult to pay for services that Medicaid no longer covered.

To reduce Medicaid's spending for nursing home and other long-term care services for the elderly, the federal government could require more assets to be included in the determination of eligibility for the program or place stricter limits on the gross income that enrollees could have—for example, by restricting options for "spending down" to eligibility. With certain exceptions, the Deficit Reduction Act made individuals who have more than $500,000 in home equity ineligible for nursing home benefits under Medicaid (although states may raise that limit to $750,000). Requiring enrollees to use more of their home equity before they could qualify for Medicaid would further reduce program spending. (At the same time, few additional options may be available for restricting or penalizing transfers of assets by Medicaid enrollees.)

Tightening eligibility rules would primarily shift the sources of financing of long-term care, but it might also reduce total spending on such care. As people came to understand that their likelihood of being eligible for Medicaid was significantly lower than it had been under current law, they would be more likely to make their own preparations for impairment in old age—by setting aside savings (if they chose to self-insure) or by purchasing private LTC insurance. And if they did become impaired and were unable to obtain assistance from Medicaid, they would be more likely to seek lower-cost providers and use fewer services as a way to conserve their resources—or they might rely more heavily on informally provided care. Such changes in Medicaid's rules would probably need to be phased in gradually, however, to give individuals time to adjust their financial planning—

because those who are close to entering a nursing home would have limited options for increasing savings or purchasing private insurance.

Increase Beneficiaries' Cost Sharing

Building on the provisions of the DRA, the federal government could take further steps to require Medicaid enrollees to share the costs of services or pay premiums for coverage. The magnitude of the additional savings that would be generated as a result and the option's impact on enrollees would depend on the specific features of the proposal. The primary effect of such changes would be to reduce federal spending by increasing the share of costs borne by enrollees. To the extent that beneficiaries reacted to the higher level of cost sharing by using fewer services, total health care costs would also fall, and federal spending would decline further. However, opponents of such an approach fear that beneficiaries might forgo necessary treatment, which could lead to poorer health and possibly greater demand for more-extensive treatment later. Higher premiums could also discourage some eligible individuals from enrolling in Medicaid.

Encourage Greater Use of Lower-Cost Services

A potentially more appealing option would be to reduce Medicaid's spending by encouraging greater use of lower-cost services while limiting the use of services that were not cost-effective—but achieving savings in that way could prove difficult. For example, the federal government might be able to encourage more use of community-based alternatives to nursing home care, given that community-based care is usually much less expensive per person than is institutional care. The potential demand for community-based services, however, is greater than the demand for institutional care. As a result, expanded coverage of community-based care is likely to substitute for some informal care provided in the home. If the expansion was not well targeted, the costs of meeting that increased demand for care could exceed the savings that might be generated by substituting community-based care for nursing home care.

More generally, Medicaid could seek to focus its spending on cost-effective services and limit or eliminate coverage for specific services that provided only modest benefits. Program administrators could directly implement such an option or rely on managed care organizations to limit the use of low-value services. Under either approach, questions might be raised about how the cost-effectiveness of services was determined and how the coverage rules were applied. Medicaid has already expanded its use of managed care contracts substantially, and insurance companies may not be willing to bear the financial risk of providing Medicaid's other benefits or serving its other enrollees. Whatever approach was taken, an important focus for the future—both in the Medicaid program and in the health sector as a whole—would be to ensure that additional spending brought benefits that were worth their cost.