

## FLORIDA'S HEALTH AT RISK

Second in a series of educational briefs on issues impacting Florida's families

# Florida's Medicaid Budget: Why are Costs Going Up?

## SUMMARY OF FINDINGS

- In times of recession, Florida's Medicaid costs can be expected to increase. Over the past five years, Medicaid costs in Florida have increased, on average, 12.5 percent. This rate of increase is likely to slow down. Our analysis shows that *enrollment increases have accounted for, on average, 62 percent of Florida's Medicaid cost increases during this period. The remainder of the increase is due to growth in health care costs.*
- When enrollment increases are accounted for, Medicaid has grown consistently at a much lower rate in recent years than health care costs in the private sector. In 2003, *private insurance costs nationally increased by just under 14 percent, while Florida's per capita Medicaid cost increase was just under five percent.*
- *Florida's Medicaid budget can expect to see some relief from the recently enacted federal Medicare prescription drug benefit.* While precise estimates are not yet available, the potential for savings is greatest for Florida since the state's share of spending on dual-eligibles that goes to prescription drugs is the highest in the country

## Overview

Health care spending in general has increased sharply over the past few years, and Medicaid in most states has not been exempt from this trend – in part because enrollment has increased in tough economic times. These increases have precipitated a desire on the part of Florida state officials to “investigate strategies for developing predictability in (Medicaid) growth by ensuring appropriate care in the appropriate setting for the people we serve.”<sup>1</sup>

*Medicaid plays a vital role in Florida's health care system, financing a broad range of services including 43 percent of all births in the state, serving 52 percent of people with HIV/AIDS care, and paying for 66 percent of all nursing home days.<sup>4</sup>*

This policy brief seeks to examine some basic questions about Florida's Medicaid costs. Why have Medicaid costs been rising? How do increases in Medicaid compare to increases in health care costs generally? How might Medicaid restructuring impact these dynamics?

## Introduction

Florida's Medicaid program provides health care coverage and services to over 2.2 million Floridians.<sup>2</sup> Medicaid provides comprehensive health coverage and long term care services to a diverse population including low-income families with children, persons with disabilities, and seniors (See Figure 1). In addition, Medicaid provides prescription drug and long term care coverage for seniors and persons with disabilities who receive Medicare.<sup>3</sup> The beneficiaries are diverse, with Medicaid playing an especially important role for the state's minority population. For example, in 1998, 39.9 percent of the beneficiaries were white, non-Hispanic; 34.9 percent were Black

and 16.1 percent were Hispanic (Source: See Figure 1). Medicaid plays a vital role in Florida's health care system, financing a broad range of services including 43 percent of all births in the state, serving 52 percent of people with HIV/AIDS care, and paying for 66 percent of all nursing home days.<sup>4</sup>

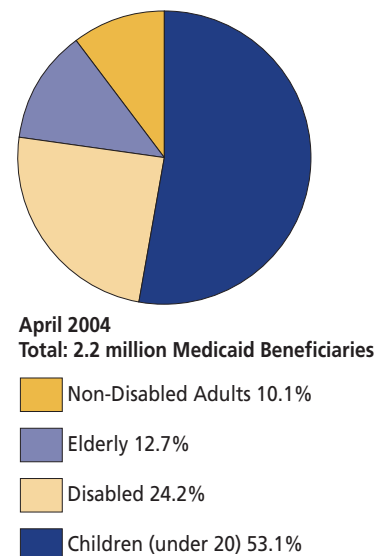
Medicaid is jointly financed by the federal and state governments. Florida's matching rate is currently just under 59 percent<sup>5</sup> which means that for every dollar the state spends on Medicaid services, it is reimbursed 59 cents by the federal government. Figure 2 on page two shows Florida's Medicaid budget over the current five year period, and how much of that spending is federal dollars and how much comes from state funds.

Federal Medicaid funding provides important economic benefits to states. Because these dollars enter from out-of-state, they stimulate positive economic activity – including the creation of jobs and business activity in Florida.<sup>6</sup>

## Why have Medicaid costs been going up?

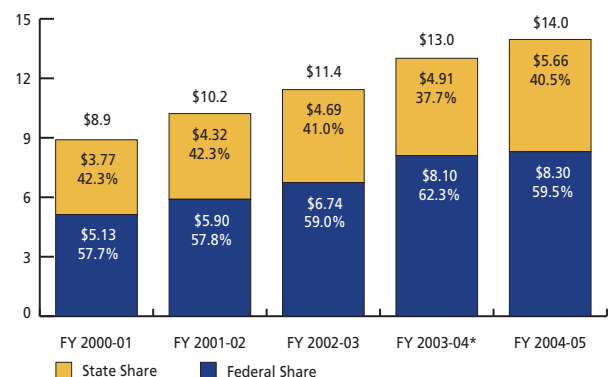
Health care costs are inherently unpredictable. A new epidemic or a new prescription drug to treat breast cancer cannot

**Figure 1: Demographics of Medicaid Beneficiaries in Florida**



Source: AHCA Bureau of Program Analysis, June 2004; HCFA, CMSO, HCFA-2082 Report, January 27, 2000.

**Figure 2: Federal and State Share of Florida’s Medicaid Expenditures** (billions)



\* Note: For FY 2003-2004, Florida, like all states, received a temporary FMAP increase of 2.95% as part of the “Jobs and Growth Tax Relief Reconciliation Act of 2003.” This enhanced matching rate expired on July 1, 2004.

Source: Medicaid expenditure data received from AHCA Bureau of Program Analysis, June 2004.

be foreseen. In recent years, health care costs have been rising for both public and private health insurance. This increase in health care costs is due to a number of factors, most prominently prescription drug and hospital costs.<sup>7</sup> Analysts expect this increase in health care costs to abate somewhat in the current year:

It is now clear that we have entered a period of decelerating cost trends following a steep acceleration during 1996-2001. Nevertheless, the cost trend remained high by historical standards and continued to outpace U.S. economic growth by a sizable margin.<sup>8</sup>

Medicaid budgets in every state have been subject to these pressures – increasing health care costs and rising enrollment at a time when the state tax revenues needed to support the program were declining. During the recent recession, Medicaid and the State Children’s Health Insurance Program picked up 4.1 million children and their parents nationally.<sup>9</sup>

Fortunately, the economic climate is improving. State revenue collections have started to grow which will lessen pressures on state budgets. Florida, in particular, saw its quarterly tax collection rise by a robust 8.6 percent from the first quarter of 2003 to the first quarter of 2004 – a much larger increase than the national average of 5.5 percent.<sup>10</sup> In addition, nationally, Medicaid cost growth is slowing down. Costs are expected to rise by just four percent in 2005 as compared to an expected increase of eight percent in 2004.<sup>11</sup>

In Florida, Medicaid enrollment started to increase steadily in 1999 in large part due to the economic downturn. The average monthly Medicaid caseload increased from 1.8 million in 2000 to 2.2 million today. Increases in categories most likely to be affected by the economic downturn were sharpest. For example, children whose incomes fall below the poverty line increased from 312,080 in 2000-01 to 453,206 in 2003-04 – a 45 percent increase.<sup>12</sup> In addition, Florida’s low-income elderly population is growing at eight times the national average,<sup>13</sup> and enrollment among this population has increased sharply as well. This group is the most expensive to serve because of their high health care needs.

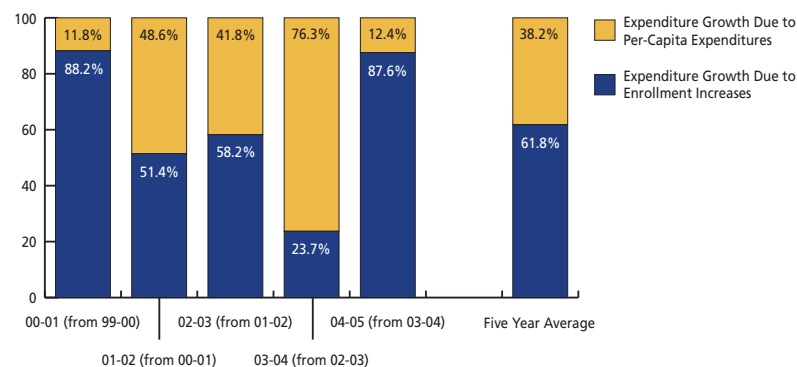
As in other states, Florida’s Medicaid budget has been rising – an average of 12.5 percent over the past five-year

period. Why have these costs been going up? Over the past five years our analysis shows that enrollment increases account for, on average, 62 percent of Florida’s Medicaid cost increases.<sup>14</sup> The remaining 38 percent can be attributed to increases in health care costs and other factors. Figure 3 below illustrates how much of the increase in Florida’s Medicaid budget in each year over the past five-year period can be attributed to enrollment increases and how much to other factors.

### How do Medicaid cost increases compare to increases in the private sector?

Medicaid serves a sicker and older population than the private insurance market. For this reason, Medicaid costs can be expected to be higher. Yet Medicaid provider payment levels tend to be significantly lower than reimbursement in the private sector which has the effect of making Medicaid a very inexpensive provider of health care services.<sup>15</sup> Findings from a recent national study looking at this question are shown in Table 1 on page three.<sup>16</sup> For more comparable populations, such as able-bodied adults, Medicaid services are significantly cheaper. When all Medicaid beneficiaries are considered, including seniors and persons with disabilities who have high health care needs, Medicaid is more costly than private insurance (for

**Figure 3: Sources of Florida’s Medicaid Expenditure Growth**



Source: Georgetown Health Policy Institute analysis based on Florida Social Services Estimating Conference Medicaid Caseload data, 2/6/04; Medicaid expenditure data from AHCA Bureau of Program Analysis, June 2004.

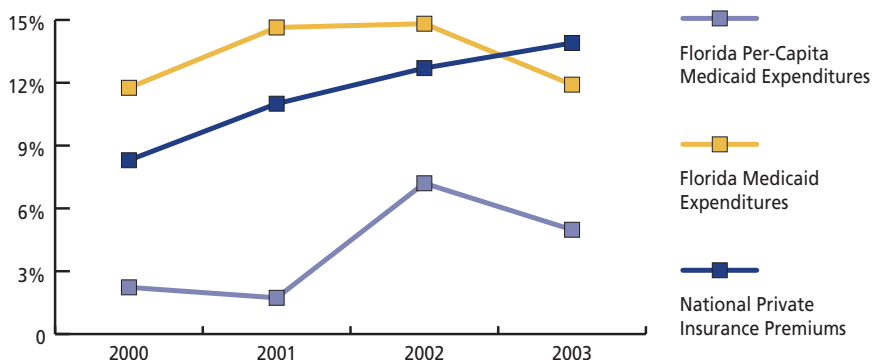
adults only). Children covered by Medicaid are significantly less costly than those covered in the private sector, even when children with disabilities are included.

Despite the fact that Medicaid serves a sicker and older population, Figure 4 shows that Florida's Medicaid costs, when looked at on a per capita basis to account for increases in enrollment, have been increasing much more slowly than private insurance premiums. Over the five-year period examined, private insurance premium costs increased on average ten percent while Florida's average per capita Medicaid growth rate was just four percent. In 2003, private insurance costs nationally increased by just under 14 percent, while Florida's Medicaid per capita cost increase was just under five percent.<sup>17</sup>

### Services for dual-eligibles: A growth area in Medicaid's budget.

Nationally, 42 percent of Medicaid spending is for Medicare beneficiaries – the so-called “dual-eligibles” – persons who are eligible for both programs.<sup>18</sup> In Florida this figure is slightly higher – 43.5 percent.<sup>19</sup> Medicaid fills in the gaps for the Medicare program by providing prescription drugs and long term care services as well as paying Medicare premiums and other cost-sharing for very low-income seniors. This area of the Medicaid budget has been growing rapidly and will continue to do so as the population ages – in part because dual-eligibles tend to be sicker and have higher health care costs than other Medicare beneficiaries.

**Figure 4: Private Insurance Premium Increases vs. Florida's Medicaid Costs, 1998-2003**



Note: Florida data represents Medicaid expenditures for July 1-June 30th of that fiscal year.

Source: Georgetown Health Policy Institute analysis based on Kaiser HRET 2003 Annual Survey, Florida Social Services Estimating Conference Medicaid Caseload data, 2/6/04; Medicaid expenditure data from AHCA Bureau of Program Analysis, June 2004.

While the largest share of Medicaid spending for dual-eligibles goes for long term care services, the second largest component is prescription drug spending. States can expect some budget relief as a result of the recently enacted Medicare prescription drug legislation which, as of 2006, will provide prescription drug coverage to dual-eligibles.<sup>20</sup> The fiscal impact of this legislation on state budgets is a mixed bag, as states will experience higher administrative costs and will be required to make what amounts to a maintenance-of-effort payment for the prescription drug costs of the dual-eligible population.<sup>21</sup> In addition, the prescription

drug coverage offered to seniors will not be as comprehensive as coverage currently offered by Medicaid, so states may wish to provide supplemental coverage, although they will have to do so at 100 percent state expense.

Yet, the required maintenance-of-effort payment diminishes over time resulting in growing savings for states. States will be affected differently by the formula that will determine these payments. National estimates of the state-by-state impact are not yet available. However, for policymakers in Florida considering ways to restructure Medicaid, it will be very important to develop accurate estimates of the likely impact this legislation will have on Florida's Medicaid budget. This is particularly important because, as Figure 5 on the next page shows, Florida's share of spending on dual-eligibles that goes for prescription drugs is the highest in the country.<sup>22</sup>

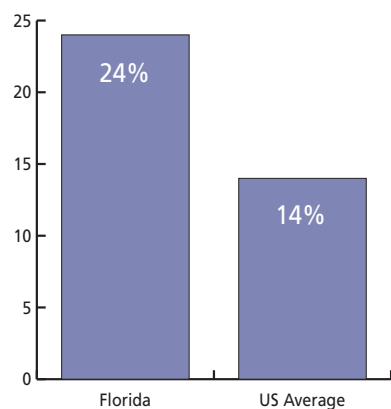
Thus, Florida's Medicaid budget is more likely than other states to experience some relief over time as the Medicare prescription drug benefit becomes available and state maintenance-of-effort payments decline. Examining these questions will be essential for policymakers considering major Medicaid reform with respect to the impact on the state's Medicaid budget and the scope of the prescription drug benefit that will be made available to Florida's low-income seniors.

**Table 1: Annual Per-Person Medical Expenditures for Low-Income Persons, 2001**

	All People	Excluding People with Disabilities
<b>Children</b>		
Private insurance	\$1,344	\$1,098
Medicaid	\$924	\$749
<b>Adults</b>		
Private insurance	\$2,843	\$2,253
Medicaid	\$4,877	\$1,752

Source: Hadley J, Holahan J. "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry Winter 2003-2004* (40): 323-342.

**Figure 5: Florida Spends More on Prescription Drugs as a Proportion of its Spending on Dual-Eligibles Than Any Other State**



Source: Bruen B, Holohan J. “Shifting the Cost of Dual-Eligibles: Implications for States and the Federal Government.” *Kaiser Commission on Medicaid and the Uninsured*, November 2003.

## Conclusion

Recent increases in Florida’s Medicaid costs are primarily the result of enrollment increases – stemming in part from the recent economic downturn – as well as increases in health care costs, which all payers in the health care system are experiencing. Florida’s Medicaid costs are actually growing at a considerably slower rate than health care costs in the private sector. Some bright spots exist for Florida’s Medicaid budget – in the short term the state’s fiscal picture is improving with tax collections rebounding – and in the longer term the new Medicare prescription drug benefit should provide Florida’s Medicaid program with some fiscal relief.

## Endnotes

- <sup>1</sup> Statement by AHCA officials at Medicaid reform meeting held in Tallahassee June 2004.
- <sup>2</sup> Enrollment data from Katherine Sanders, AHCA Bureau of Program Analysis, 4/15/04.
- <sup>3</sup> For a detailed description of the Medicaid program see Andy Schneider, Risa Elias, Rachel Garfield, David Rousseau, and Victoria Wachino, *The Medicaid Resource Book* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2002). Also for more information on Florida’s Medicaid

program, see *Florida Medicaid: Summary of Services FY 2003-2004* (Tallahassee: Agency for Health Care Administration) available at <http://www.fdhc.state.fl.us/Medicaid/sos.pdf>

<sup>4</sup> *Florida Medicaid: A Status Report* The Florida Legislature, January 9, 2003.

<sup>5</sup> As of July 1, 2004.

<sup>6</sup> For more information on this phenomenon, known as the “multiplier effect,” see Priya Sampath, *Penny Wise and Pound Foolish: Why Cuts to Medicaid Hurt Florida’s Economy* (Miami: Human Services Coalition of Dade County, October 2003).

<sup>7</sup> Bradley C. Strunk, and Paul B. Ginsburg, “Tracking Health Care Costs: Trends Turn Downward in 2003,” *Health Affairs* – Web Exclusive, June 9, 2004.

<sup>8</sup> *Ibid.*

<sup>9</sup> Leighton Ku, *CDC Data Show Medicaid and SCHIP Played a Critical Countercyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn* (Washington, DC: Center on Budget and Policy Priorities, October 8, 2003).

<sup>10</sup> Nicholas W. Jenny, *State Tax Revenue Recovery Gathering Steam* (Albany, NY: Rockefeller Institute of Government, June 2004).

<sup>11</sup> Congressional Budget Office Medicaid March 2004 baseline.

<sup>12</sup> Enrollment data from the Social Services Estimating Conference “Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05,” February 6, 2004.

<sup>13</sup> Joan Alker, and Lisa Portelli, *What Could a Waiver to Restructure Medicaid Mean for Florida?* (Orlando: Winter Park Health Foundation, April 2004).

<sup>14</sup> Georgetown Health Policy Institute analysis based on enrollment data from the Social Services Estimating Conference “Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05,” February 6, 2004.; Medicaid expenditure data from AHCA Bureau

of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04.

<sup>15</sup> Low provider rates, however, create problems in accessing services.

<sup>16</sup> Jack Hadley, John Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” *Inquiry* 40, no. 4 (Winter 2003-2004): 323-342.

<sup>17</sup> Georgetown Health Policy Institute analysis based on Kaiser HRET 2003 Annual Survey; Florida Social Services Estimating Conference “Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05,” February 6, 2004; Medicaid expenditure data from AHCA Bureau of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04. Florida data for state fiscal year 1998-1999 is referred to as 1999 (etc.) for comparative purposes.

<sup>18</sup> *Dual Eligibles: Medicaid’s Role in Filling Medicare’s Gaps* (Washington DC: Kaiser Commission on Medicaid and the Uninsured, March 2004).

<sup>19</sup> Data provided by AHCA Bureau of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04. Expenditures for Dual Eligibles for FY 2001-02.

<sup>20</sup> H.R. 1 The Medicare Prescription Drug Improvement and Modernization Act of 2003.

<sup>21</sup> This is often referred to as the “clawback” provision of the law. For more information, see Jocelyn Guyer, *Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2003).

<sup>22</sup> Brian Bruen, and John Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government* (Washington, DC: Kaiser Commission on the Uninsured, November, 2003). In addition, since this data was collected, Florida established the “Silver Saver” program under a Medicaid Section 1115 waiver which offers expanded prescription drug coverage to low-in/come seniors.

## FLORIDA’S MEDICAID BUDGET: WHY ARE COSTS GOING UP?

Second in a series of educational briefs on issues impacting Florida’s families – Florida’s Health at Risk. Published by the Winter Park Health Foundation.



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