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**THE MEDICAID-MEDICARE LINK:
STATE MEDICAID PROGRAMS ARE SHOULDERING A GREATER SHARE OF
THE COSTS OF CARE FOR SENIORS AND PEOPLE WITH DISABILITIES**

by Leighton Ku

Summary

The two main publicly-funded health insurance programs are Medicare — the federal insurance program for seniors and people with disabilities — and Medicaid — the joint federal-state insurance program for low-income people. Each program pays for health insurance coverage of low-income seniors and people with disabilities. This “partnership” has become strained in recent years, however, as Medicaid expenditures have surged, in large measure because of the rapidly rising costs of providing care for elderly and disabled beneficiaries who are also enrolled in Medicare. Structural gaps in coverage offered by Medicare have led state Medicaid programs to bear an increasing share of the overall costs of health care for seniors and people with disabilities.

Almost all elderly Medicaid beneficiaries and about two-fifths of disabled Medicaid beneficiaries are also on Medicare. Both programs contribute to the costs of health care for those who are enrolled in both programs, a group of beneficiaries referred to as “*dual eligibles*.” For the low-income individuals fully enrolled in both programs, Medicaid pays for services that Medicare does not cover — like prescription drugs and long-term care — and also covers the deductibles, coinsurance and premiums that Medicare assesses beneficiaries. In addition, federal law requires that state Medicaid programs provide partial coverage for Medicare beneficiaries with incomes below 120 percent of the poverty line (\$10,780 in annual income for a single person and \$14,540 for a couple). Some 35 percent of all Medicaid expenditures are on behalf of dual eligibles.

Medicaid programs, and therefore the states, are bearing a growing share of the financial responsibility for health care for seniors and people with disabilities, while the federal share under Medicare is lightening. Medicaid expenditures for care for seniors and people with disabilities have grown much faster than Medicare expenditures in recent years and the growth rates are projected to remain unequal in the future.

- In 1984, Medicaid paid for 30 percent of the total public expenditures for health insurance for the aged and disabled and Medicare paid for 70 percent. Projections from the Congressional Budget Office (CBO) indicate that, by 2012, Medicaid’s share will rise to 45 percent, while Medicare’s share will fall to 55 percent.

- CBO projects that Medicaid expenditures for seniors will grow at an average rate of 8.9 percent each year from 2002 to 2012, while Medicare expenditures are projected grow an average of 6.7 percent annually. If the Medicaid growth rates for seniors could be brought down to the levels projected for Medicare, cumulative state expenditures for Medicaid would be \$47 billion lower over the period 2003 to 2012. If Medicaid growth rates for people with disabilities could be brought down to Medicare levels, the savings for states could be even larger.

The growing expenditure gap between the programs is primarily caused by structural deficiencies in Medicare coverage:

- Medicare does not cover outpatient prescription drugs, so Medicaid must cover all prescription drug costs for Medicare beneficiaries fully enrolled in both programs. The cost of prescription drugs is the fastest growing segment of health care spending. More than half (about 57 percent) of all Medicaid expenditures for prescription drugs are incurred for beneficiaries who are enrolled in Medicare.
- Medicaid covers long-term care, while Medicare does not (aside from short-term costs to help those recuperating after being hospitalized). A majority of the Medicaid expenditures for seniors and people with disabilities are for long-term care services, such as nursing home or home health care services. As baby boomers age and retire, Medicaid's long-term care costs will grow heavier.
- Changes in medical practices over time have reduced the length of time that people are hospitalized and increased the use of ambulatory care and prescription drugs. While these shifting medical practices can reduce overall health care costs, they have the paradoxical effect of increasing Medicaid expenditures while lowering Medicare costs. This is because reducing hospital expenditures for a dual eligible saves substantial sums for Medicare (which is the "primary payer" for hospital expenses for dual eligibles) but not Medicaid, while additional expenses for prescription drugs are borne by Medicaid but not Medicare.
- Medicaid expenditures are *not* growing faster than Medicare expenditures because state Medicaid programs are less efficient or pay providers more generously. Medicaid generally pays health care providers less than Medicare and Medicaid payment rates have risen more slowly. Moreover, a far greater share of Medicaid beneficiaries are in managed care plans than in Medicare.

The rising costs of health care for elderly and disabled beneficiaries and the shift in costs from Medicare to Medicaid are the primary forces driving up state Medicaid expenditures, which are, in turn, the fastest growing component of state budgets. *Three-quarters* of the projected growth in total Medicaid expenditures, as projected by CBO, is caused by the rising costs of care for the aged and disabled. As the baby-boom generation ages, these costs are likely to prove unsustainable by state governments. The federal government could act to restore the balance of financial responsibilities between Medicaid and Medicare and redress the shifting of costs from

the federal government to states, as a mechanism to help reduce long-term fiscal burdens for states and to improve care for Medicare beneficiaries.

In the coming year, the Administration and Congress have announced their intention to address important changes in the Medicare program, including a Medicare prescription drug benefit and other structural reforms in Medicare. The Medicare policies adopted could have a profound effect on the long-term costs of the Medicaid program and, therefore, on state budgets. A Medicare prescription drug benefit could, depending on how it is designed, greatly reduce Medicaid outlays because Medicare could assume the great majority of drug costs for the dually eligible. On the other hand, structural changes to Medicare — like a “premium support” arrangement, one Medicare reform approach often raised — could increase beneficiaries’ share of costs and thereby force state Medicaid costs higher, since Medicaid covers such costs for low-income Medicare beneficiaries. Another strategy that could be considered would be to increase federal financing for the care of dual eligibles by increasing the federal Medicaid matching rate for services received by this group, for selected services such as prescription drugs, or for selected groups such as Qualified or Specified Low-income Medicare Beneficiaries (those with incomes above full Medicaid eligibility levels but below 100 percent of the poverty line or between 100 percent and 120 percent of the poverty line, respectively).

In establishing future policies for Medicare and health care for seniors and people with disabilities, federal policy-makers will consider a number of factors, including the cost to the federal government and the well-being of Medicare beneficiaries. Federal policy-makers also ought to consider the budgetary impact of Medicare reforms on states, their partners in care for seniors and people with disabilities. In so doing, federal policy-makers should bear in mind that while certain changes in Medicare could provide substantial relief to states in the long term, they might not do little to ease the immediate crises states are experiencing during the current economic downturn. Congress could consider complementary policies to offer temporary relief to states as part of a short-term economic stimulus package, along with longer-term policy changes that improve health care coverage for seniors and people with disabilities in a manner that provides some relief to states from the escalating health care costs they otherwise would have to shoulder for these groups.

Background on the Roles of Medicaid and Medicare

Medicare provides medical insurance coverage to about 34 million elderly beneficiaries — almost all of the seniors in the United States — and about 6 million non-elderly people with disabilities (those who receive Social Security Disability Insurance or who have severe kidney disease (“end stage renal disease”). Medicaid covers an estimated 5 million low-income seniors and 8 million low-income people with disabilities. Almost all elderly Medicaid beneficiaries also receive Medicare, as do about two-fifths of disabled Medicaid beneficiaries.¹

¹ People with disabilities who qualify for Medicaid but not Medicare include disabled children and adults who did not work enough years to qualify for Social Security Disability Income (SSDI), as well as those who qualify for SSDI but have not yet met the two-year waiting requirement for Medicare benefits. See Marilyn Ellwood and Brian Quinn, “Background Information on Dual Eligibles in FY 1999,” Mathematica Policy Research, Inc., Feb. 28, 2002.

Types of Medicaid-Medicare Coverage

Medicaid offers varying degrees of coverage for Medicare beneficiaries:

- **Full Coverage.** Seniors and people with disabilities who are fully eligible for *Medicaid* — because they are Supplemental Security Income (SSI) beneficiaries, are “medically needy” or meet other Medicaid eligibility criteria — receive the comprehensive set of services Medicaid covers, including prescription drugs and long-term care.¹ For services that are covered by *Medicare*, such as inpatient hospital care, physician services, other acute care services and post-acute care (e.g., limited long-term care for those recuperating after hospitalizations), Medicare is the “primary payer” and Medicaid is responsible for covering the costs of the deductibles and coinsurance required under Medicare. For example, if such a person uses physician services, Medicaid will pay the \$100 Medicare deductible for ambulatory services and 20 percent of the remaining Medicare-approved amount. These would otherwise be the cost-sharing obligations the beneficiary would have to pay.³ Medicaid also pays the monthly Medicare premiums on behalf of the dual eligibles (e.g., \$58.70 per month for Part B physician service premiums in 2003). For health services not covered by Medicare, such as outpatient prescription drugs and most long-term care services, Medicaid is responsible for all of the costs.⁴
- **Partial Coverage (Medicare Savings Programs).** Other low-income elderly and disabled Medicare beneficiaries are eligible for partial benefits under Medicaid. State Medicaid programs must cover the Medicare-related premiums, deductibles and coinsurance for Qualified Medicare Beneficiaries (QMBs). These are people who have incomes below 100 percent of the poverty line but above the levels that would qualify them for full Medicaid coverage in their state. Unless they are fully eligible for Medicaid, QMBs are *not* covered for services like prescription drugs or long-term care. Certain other low-income Medicare beneficiaries are eligible for even more limited assistance under Medicaid programs.⁵ Federal requirements that Medicaid cover these groups have been gradually added since 1988. In large measure, these requirements are designed to protect low-income Medicare beneficiaries from cost-sharing responsibilities that have grown over time and that they would have difficulty affording on their own.
- **Prescription Drug Coverage.** In several states, under recently approved state pharmacy waiver programs, low-income Medicare beneficiaries who are not fully eligible for Medicaid can obtain prescription drug coverage, paid by the state’s Medicaid program. Because these are state waiver programs, the eligibility criteria and breadth of coverage vary from state to state and there may be limits on the number of people who can enroll, so that additional applicants could be turned away or placed on waiting lists.

¹ SSI beneficiaries generally have countable incomes below \$6,600 a year for a person living alone or about \$9,950 for a couple, which is equivalent to 75 percent to 83 percent of the poverty line. There is some variation in SSI-related eligibility for state to state, including a number of “Section 209(b)” states that use eligibility criteria more restrictive than the federal standards. Medically needy people qualify if they meet Medicaid income criteria after the costs of health services they incur are subtracted from their income; these people “spend down” into Medicaid eligibility. A number of states also establish eligibility for seniors or the disabled, based on whether their incomes are less than some percentage of the poverty line, such as 100 percent of poverty.

² State Medicaid programs have the option of making coinsurance payments to providers based on either Medicare or Medicaid payment rates. Thus, if Medicaid payment rates are lower than Medicare rates, the coinsurance paid by Medicaid may be smaller than the amount required under Medicare.

³ Under certain circumstances, Medicare pays for outpatient drugs, such as under some Medicare+Choice managed care plans, but in general it does not cover medications. Medicare covers prescription drugs used in hospitals or nursing homes or administered directly by physicians

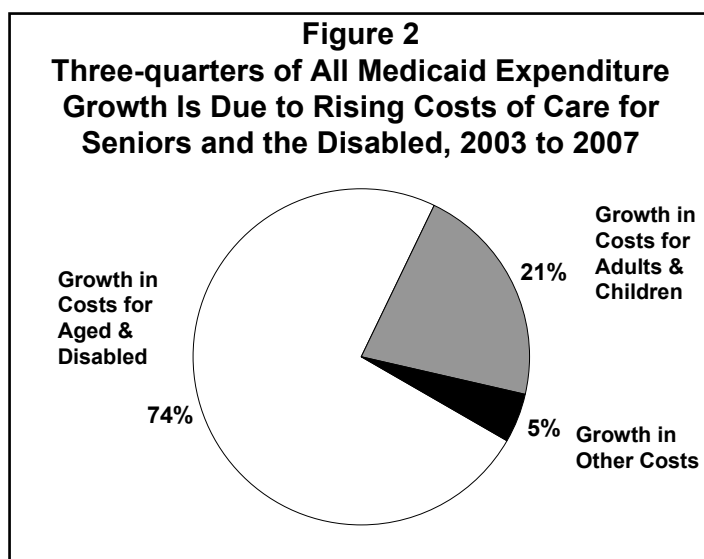
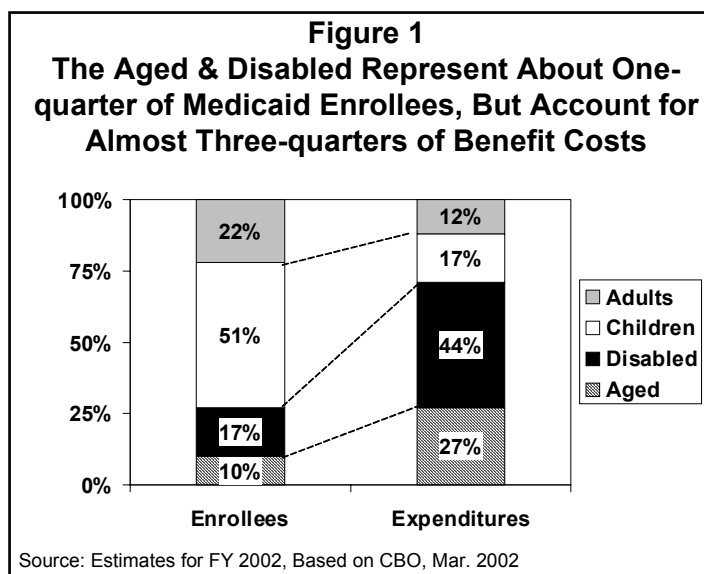
⁴ For Specified Low-income Medicare Beneficiaries (SLMBs), those incomes between 100 percent and 120 percent of the poverty line, Medicaid pays for the monthly premiums for Part B of Medicare, but does *not* pay for deductibles and copayments. For Qualifying Individuals (QI-1s), those with incomes between 120 percent and 135 percent of the poverty line, Medicaid covers Part B Medicare premiums. Benefits for QI-1s are paid by federal grants; there is not state matching requirement nor an entitlement to coverage. There had been a Qualifying Individual-2 program for those with incomes between 135 and 175 percent of poverty, but this expired December 31, 2002. Qualified Working Disabled Individuals (QWDIs) are certain disabled individuals who have returned to work and have incomes below 200 percent of the poverty line; Medicaid pays their Medicare part A hospital premiums.

Most of the Growth in Medicaid Expenditures Is Driven by Costs for Seniors and People with Disabilities

In 1999, some 35 percent of all Medicaid expenditures were for care provided to Medicaid beneficiaries who were dually enrolled in Medicare.² It is likely that the share has grown since then, given the continuing growth in costs for elderly and disabled beneficiaries, discussed in more depth below.

As seen in Figure 1, while seniors and people with disabilities are about one-quarter (27 percent) of all Medicaid beneficiaries, they are responsible for almost three-quarters (72 percent) of all Medicaid benefit expenditures. This is because seniors and people with disabilities have more serious medical needs than other enrollees and, therefore, higher average expenditures for both acute medical care and long-term care services. On average, the average cost of serving an aged or disabled person in Medicaid is about *eight times* the average Medicaid cost of serving a child and six times the average Medicaid cost for a non-elderly, non-disabled adult. Moreover, dual eligibles have exceptionally high health care needs and expenditures, compared to other seniors. Dual eligibles have poorer health status and were much more likely to have serious health problems, such as diabetes, pulmonary disease or Alzheimer's disease, than other Medicare beneficiaries who are not enrolled in Medicaid. Data from the Centers for Medicare and Medicaid Services show that in 1999, the average total health expenditures of dual eligibles were twice as high as those of other Medicare beneficiaries.³

Equally important, projected growth in the costs of care for seniors and people with disabilities is the primary source of long-term Medicaid cost pressures. As shown in Figure 2,



² Centers for Medicare and Medicaid Services, "Profile of Medicare Dually Eligible Beneficiaries," presentation at the Secretary of Health and Human Services' Advisory Committee on Regulatory Reform, June 10-11, 2002.

³ *Ibid.*

Table 1
Components of Average Annual Medicaid Federal Expenditure Growth, FY 2003 to 2007

	Average Annual Increase in Health Care Costs for Serving the Current Caseload	Average Annual Increase in Costs Due to Additional Enrollees	Average Increase in Costs Due to Other Expenses*	Total
Total	5.9%	2.1%	0.4%	8.4%
Aged	1.1%	0.9%	—	2.0%
Disabled	3.1%	1.1%	—	4.2%
Children	1.0%	-0.1%	—	0.9%
Adults	0.7%	0.1%	—	0.8%
Other*	—	—	0.4%	0.4%

* Other includes administrative costs and disproportionate share hospital and upper payment limit payments.
Source: CBPP analyses of CBO Medicaid estimates, March 2002

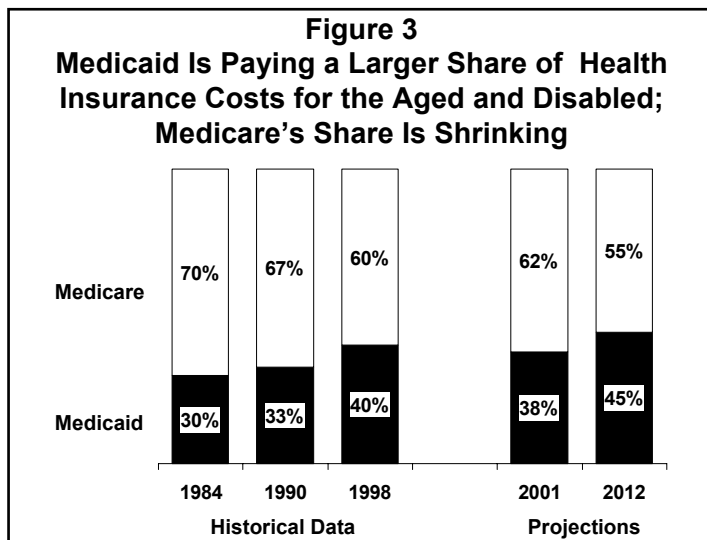
rising costs of care for the aged and disabled comprise three-quarters of total Medicaid expenditure growth from 2003 to 2007, based on Congressional Budget Office projections. Table 1 provides more detail about the factors that are projected to affect Medicaid expenditure growth over the next several years. As can be seen, costs of care for seniors and people with disabilities are expected to increase due to rising health care costs as well as growth in enrollment. While CBO expects that enrollment of aged and disabled beneficiaries will rise in the coming years, the number of children and adults enrolled in Medicaid is projected to change relatively little. As the baby boomers age and retire, Medicaid expenditures for the aged and disabled will even become more dominant.

Medicaid’s Expenditures for Seniors and People with Disabilities Are Growing Faster Than Medicare’s

The costs of caring for seniors and for people with disabilities in Medicaid are also growing faster than the costs of serving these people in Medicare, for reasons discussed later. As a result, state Medicaid programs have been shouldering a larger fraction of total public expenditures for health care for the aged and disabled, and the Medicare program has been bearing a smaller share. The share of total public expenditures for health care for the aged and disabled that is paid by Medicaid grew from 30 percent in 1984 to 40 percent by 1998 and is projected to rise to 45 percent by 2012, while the share paid by Medicare has been waning, dropping from 70 percent in 1985 to a projected 55 percent in 2012 (Figure 3).⁴

⁴ These analyses compare total (state plus federal) Medicaid expenditures for the aged and disabled with federal Medicare expenditures. Historical data for the 1984 to 1998 period are drawn from Urban Institute tabulations of Medicaid expenditure data and federal Medicare expenditure data. For the 2001 to 2012 period, we use CBO projections. It seems likely that the apparent reduction in Medicaid’s share from 1998 to 2001 is due to definitional differences in the actual and projected data, rather than because of an actual reduction during that period. Comparable historical data for 1999 and 2000 are not available. The available data for the two periods (1984-98 and 2001-12) each show consistent increases in the Medicaid share of costs. All comparisons are for benefit expenditures and exclude items such as administrative costs or Medicaid disproportionate share hospital payments.

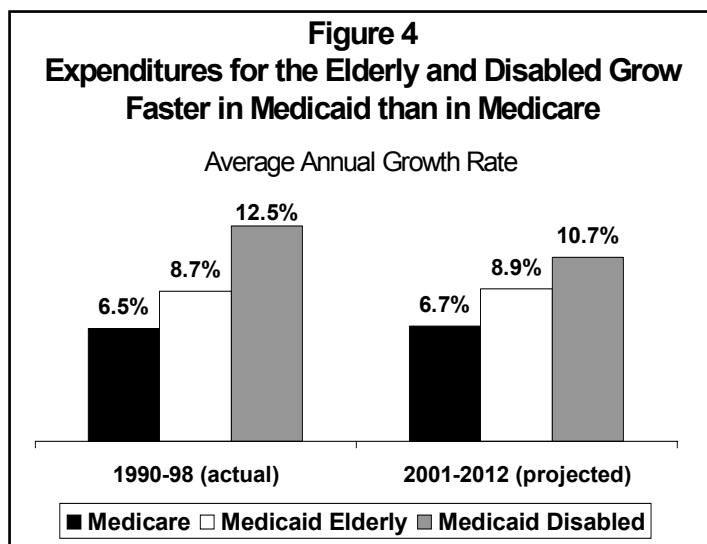
Health care expenditures for both programs are growing, but those for Medicaid have been growing significantly faster. Figure 4 compares historical and projected annual growth rates for Medicaid and Medicare expenditures for the aged and disabled. The growth in Medicaid expenditures for the aged is about one-third faster than the growth rate for Medicare. The growth in Medicaid costs for people with disabilities is also much higher than the growth in Medicare costs.



The differences in expenditure growth rates contribute to substantially higher costs for states. If Medicaid expenditures for the elderly rose at the same rates that CBO has projected for Medicare expenditures between 2002 and 2012, states would spend \$47 billion less in state funds in the ten-year period from 2003 to 2012 than the level currently projected. If projected Medicaid expenditures for people with disabilities grew at the same rate as Medicare spending each year, states would spend \$142 billion less in state funds from 2003 to 2012.⁵

Medicaid Expenditures Are Rising Because of Gaps in Medicare Coverage

The primary factor driving Medicaid expenditures higher is the rising costs of health care for aged and disabled beneficiaries. In this section, we find that gaps in Medicare coverage are the main reason these Medicaid expenditures have grown so quickly.



One key reason for the rapid growth of Medicaid expenditures is the lack of an outpatient prescription drug benefit in Medicare. Medicaid has sole responsibility of paying for prescription drugs for those who are dually enrolled. Pharmaceuticals are the fastest growing component of health care expenditures, and elderly and disabled beneficiaries account for 85

⁵ Only a portion of the \$142 billion is attributable to dually eligible people with disabilities. Medicaid data on the costs of serving the disabled combine the costs of the 40 percent of Medicaid disabled beneficiaries who are dually enrolled with costs for the 60 percent who are enrolled in Medicaid alone. We lack information on the comparative costs of these two groups of disabled Medicaid beneficiaries.

An Example of How New Medical Practices that Lower Medicare Costs Can Increase Medicaid Costs

Consider a simplified example for a person dually enrolled in Medicaid and Medicare. Imagine that a new approach to treating this patient's illness reduces the costs of treatment from \$22,000 (\$15,900 in hospital costs, \$4,100 in physician payments and \$2,000 in outpatient drug costs) to \$17,000 (\$5,900 hospital costs, \$6,100 in physician payments and \$5,000 in drugs). From an overall perspective, the new treatment approach saves \$5,000.

Under the old way of treating the disease, Medicaid's share would be \$3,740 (\$2,000 for the prescription drugs, \$840 for the hospital deductible, \$100 for the physician deductible and \$800 for the 20 percent coinsurance for physician services). Medicare would pay the rest, \$18,260.

With the new approach, Medicaid would pay about \$7,140 (\$5,000 for prescription drugs, \$840 for the hospital deductible, \$100 for the physician deductible and \$1,200 for the physician coinsurance). The Medicare expenditure would be about \$9,860.

Using the new approach instead of the older one lowers Medicare expenditures by \$8,400, but increases Medicaid expenditures by \$3,400. Even though the new approach reduces overall health care expenses, Medicaid spends more.

Because Medicare has a fixed deductible for all inpatient care (during the first 60 days) and Medicaid pays the deductible for dual eligibles, the Medicaid portion of the bill is not lowered by reductions in inpatient costs, and Medicaid must cover the full increased costs of prescription drugs and also pay for a portion of the increased physician costs. Even if the increase in prescription drug costs is set aside, it is clear that Medicaid does not share in the savings that Medicare obtains through lower inpatient hospital costs.

percent of all Medicaid prescription drug expenditures.⁶ Further analyses conducted by the Center on Budget and Policy Priorities indicate that *more than half* of all the prescription drug expenditures of state Medicaid programs — 57 percent — are for beneficiaries who are dually enrolled in Medicare.⁷

Another important gap in Medicare coverage is the lack of long-term care coverage. Medicare covers limited amounts of temporary nursing home care for those recovering from serious illnesses or operations after treatment in a hospital, but does not offer the more comprehensive long-term care services needed by many frail elderly or disabled people. (By way of comparison, Medicare expenditures for nursing home care in 2002 were less than one-quarter the level of Medicaid expenditures.⁸) Expenditures for long-term care are a major cost in

⁶ This is based on data regarding state Medicaid expenditures in fiscal year 2000 as reported in the Medicaid Statistical Information System.

⁷ Our analyses estimated that dual eligibles were responsible for roughly 67 percent of all drug expenditures for the aged and disabled in Medicaid. Multiplying 67 percent by 85 percent means that 57 percent of *all* Medicaid prescription drug expenditures are attributable to the dually eligible.

⁸ Estimates based on CMS projections of national health expenditures, released in March 2002.

Medicaid and comprise 52 percent of total Medicaid expenditures for aged and disabled beneficiaries.

The lack of long-term care coverage in Medicare also means that many Medicare beneficiaries who need long-term care and whose incomes are above the traditional Medicaid eligibility thresholds — that is, above SSI income limits — must deplete their incomes and “spend down” into the Medicaid income range to gain financial assistance for long-term care. If Medicare provided long-term care services, fewer seniors would spend down and become Medicaid enrollees.

A third factor that leads to the disparate expenditure trends for Medicaid and Medicare is related to changes in medical practices. The medical advances that have occurred in recent years and are likely to continue in the future rely on greater use of outpatient treatment and medications and less use of inpatient hospital care. The average length of an inpatient hospital stay for a Medicare beneficiary fell by one-fifth from 1972 to 1998. While these medical advances can lead to better quality and more cost-effective health care, they can also result in Medicaid paying for a larger share of medical costs in the form of prescription drugs and not sharing in savings that occur through a reduction in inpatient or other acute care services (see box below for an example.)

The mismatch between changes in medical practices and the ways Medicare and Medicaid split costs for the dual eligibles also leads to incentives in Medicaid and Medicare that work at cross purposes. It is to Medicare’s financial advantage to pursue medical technology that lowers hospitalization and increases drug costs, but it is to Medicaid’s financial advantage to prefer medical practices that require fewer or less expensive prescription drugs. Patients might fare better if both programs had the same incentives to promote cost-effective care that also improves the quality of outcomes for patients.

Has Medicaid Been Less Efficient Than Medicare?

Is it possible that Medicaid expenditures for seniors or people with disabilities outpaced Medicare expenditures because states were less cost-conscious in managing Medicaid than the federal government has been in managing Medicare? Medicare has undergone significant belt-tightening since enactment of the Balanced Budget Act of 1997 (although some of the Medicare policies were loosened in 2000 and were loosened again in the recently enacted Omnibus Appropriations Act for 2003).⁹

Comparisons of Medicare and Medicaid payment rates for hospital and physician services indicate, however, that Medicaid payment rates are *significantly below* those used in Medicare and that Medicaid payment rates have grown *more slowly* than those in Medicare. For example, a 1999 Urban Institute study found that average Medicaid physician reimbursement

⁹ The Balanced Budget Act of 1997 pared Medicaid spending growth, too, by capping disproportionate share payment and giving states greater discretion in establishing capitated managed care plans and setting hospital and nursing home payment rates.

rates were 64 percent of the Medicare payment rates. Moreover, physician payment rates in Medicaid grew 14 percent less from 1993 to 1998 than Medicare payments, so Medicaid payment rates fell further behind.¹⁰ Similarly, data reported by the Medicare Payment Advisory Commission indicate that the Medicaid typically pays less for inpatient hospital care than Medicare and Medicare payments grew more rapidly in the 1992 to 2000 period than Medicaid payments.¹¹ While we lack comparative data for the most recent time periods, it is likely that Medicaid payment rates have continued to fall relative to Medicare payments: a survey of state Medicaid programs found that 22 states cut or froze provider payment rates in 2002, and 37 states plan to hold down payment rates in 2003.¹² The available data suggest that state Medicaid programs have been, on average, more aggressive in holding down health care provider payment rates than Medicare.

Another measure of cost-containment effort is the extent to which beneficiaries in each program are enrolled in managed care plans, as compared to fee-for-service care. Fewer Medicare beneficiaries are in managed care than Medicaid beneficiaries and the share of Medicare beneficiaries in managed care plans has been falling recently. In 1996, for example, 16 percent of Medicare enrollees were in Medicare+Choice plans, but this fell to 13 percent by 2002 and is expected to continue to fall.¹³ In comparison, 40 percent of all Medicaid beneficiaries were in managed care in 1996 and the level rose to 57 percent in 2001, according to federal enrollment statistics.¹⁴

Trends in Medicaid and Medicare Enrollment

A final issue is differential growth in Medicaid and Medicare enrollment. The number of seniors and people with disabilities on Medicaid has grown slightly faster than Medicare enrollment. Because Medicare is almost a universal program for seniors, enrollment levels grow gradually as the elderly population rises. The number of elderly and disabled people covered by Medicaid is affected by more factors, including changes in the number of low-income seniors or people with disabilities who are eligible, changes in participation rates and changes in federal or state eligibility rules.

¹⁰ Stephen Norton, "Recent Trends in Medicaid Physician Fees, 1993-98," Urban Institute, Sept. 1999.

¹¹ In 1992, the Medicare payment-to-cost ratio for hospitals was 89 percent; this rose to 100 percent by 2000. In contrast, the Medicaid payment-to-cost ratio for hospitals was 91 percent (including disproportionate share hospital payments) in 1992 and increased to only 96 percent by 2000. While Medicaid paid more than Medicare in 1992, it paid less by 2000. In both cases, the increases in payment-to-cost ratios are attributable to hospitals' efforts to lower their costs, as well as to increases in amounts paid by Medicaid and Medicare. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 2002.

¹² Vernon Smith, et al. *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, Kaiser Commission on Medicaid and the Uninsured, Jan. 2003.

¹³ Kaiser Family Foundation, *Medicare+Choice*, June 2002.

¹⁴ Most Medicaid managed care enrollees are children or non-disabled, non-elderly adults. Data on trends in Medicaid managed care penetration among the aged or disabled are not available.

Some Medicaid enrollment growth is related to expansions of eligibility for aged or disabled people that states initiated to fill in gaps left by Medicare coverage. For example, as of 2001, some 18 states and the District of Columbia had exercised options to expand full Medicaid coverage to seniors or people with disabilities up to the federal poverty line or some percentage of the poverty line.¹⁵ In addition, five states have received federal waivers to use Medicaid matching funds to pay for prescription drug coverage for low-income seniors, and a number of other states have applied for such waivers. In these cases, states assumed more responsibility to provide coverage to that was not available under Medicare, since the federal government was unable to reach agreement on a Medicare drug benefit. (On the other hand, some states have not raised their medically needy income levels or adjusted these levels for inflation in many years, effectively scaling back coverage in this way for seniors or people with disabilities. In addition, some states have recently reduced or are proposing to reduce eligibility for seniors or the disabled because of state budget crises.)

There also has been some enrollment growth in Medicaid as a result of the QMB and SLMB expansions the federal government enacted in 1988 and 1990. These expansions appear to have had only a modest impact on growth for state Medicaid expenditures over the past decade. In fact, a large number of eligible seniors do not avail themselves of these useful benefits. There is a broad consensus that participation levels could be improved. One recent analysis estimated that only 60 percent of aged and disabled Medicare beneficiaries who are eligible for QMB status were participating.¹⁶ Analyses of Medicaid data show that states vary widely in the extent to which they enroll seniors and people with disabilities in dual eligible programs, including QMB programs.¹⁷

Medicare Policy Choices Affect State Medicaid Programs

Changes in Medicare policies often affect Medicaid programs, thereby increasing or lowering the level of health assistance that low-income seniors and people with disabilities receive and the costs that states incur to operate their Medicaid programs. The Bush Administration and Congressional leaders have expressed a strong desire to enact a prescription drug benefit for seniors and to consider other ways to restructure Medicare benefits to contain federal costs. Some of such changes, such as a Medicare prescription drug benefit, could lower Medicaid expenditures over time and thereby ease the budgetary pressures on states. While it is beyond the scope of this paper to provide a comprehensive review of all of the relevant Medicare reform options, we can identify some key strategic options and provide a brief discussion.

¹⁵ National Association of State Medicaid Directors, *Aged Blind and Disabled Eligibility Survey*, 2002. Brian Bruen, et al. "State Usage of Medicaid Coverage for Aged, Blind and Disabled People," Urban Institute, Aug. 1999.

¹⁶ Actuarial Research Corporation, *Dual Eligible Buy-in Status*, prepared for the Centers for Medicare and Medicaid Services, May 2001.

¹⁷ Ellwood and Quinn, *op cit*.

Medicare Prescription Drug Benefit. Most of the Medicare prescription drug proposals include greater drug benefits or subsidies for low-income seniors and additional protection for those with very high (catastrophic) drug expenses.¹⁸ Beyond that, there are substantial differences in the designs of various prescription drug proposals, including difference in the scope of eligibility and benefits, cost-sharing obligations, delivery systems for providing prescription assistance, and mechanisms for cost containment.

A Medicare drug benefit might provide substantial relief for state Medicaid expenditures. The extent of any savings will depend, however, on the specifics of the plan's design. If the Medicare drug benefit becomes the "primary payer" for prescription drugs for those dually enrolled in Medicaid and Medicare — so that Medicaid pays only for premiums, deductibles, coinsurance or copayments in a fashion comparable to other Medicare-covered services — this could lower Medicaid expenditures substantially when the Medicare benefit is phased in fully. For example, the Medicare Modernization and Prescription Drug Assistance Act, passed by the House of Representatives in June 2002, would have lowered state expenditures for Medicaid by an estimated \$46 billion from 2003 to 2012, although the state savings would have been relatively small until 2006 and provided little aid during states' current fiscal crises.¹⁹ The Senate Democratic leadership recently introduced a bill (S. 7, the Prescription Drug Benefit and Cost Containment Act of 2003) that would provide even more substantial relief to states, by phasing in complete federal funding for prescription drug costs currently being covered by state Medicaid programs as well as subsidies for additional assistance that states could extend to low-income populations.

On the other hand, if the Medicare drug plan requires a state "maintenance of effort" component — so that state Medicaid programs must continue to spend as much on prescription drugs as they did before the enactment of the new legislation, then state savings would be lowered considerably. The House bill passed in 2002 reduced federal Medicaid payments to states by about \$12 billion over ten years as part of maintenance-of-effort. This lowered the level of relief offered to states, bringing down the savings for states from \$58 billion to \$46 billion.

Medicare Cost-sharing Under Broader Reform Initiatives. Other Medicare policy proposals that Congress may consider this year could redesign Medicare benefits or cost-sharing in a fashion that could increase or decrease state outlays for dual eligibles. For example, some have proposed shifting Medicare toward a "premium support" model, in which federal subsidies for Medicare are fixed and beneficiaries select coverage from competing plans with different benefit structures, including varying cost-sharing requirements.²⁰ One risk of such an approach

¹⁸ See, for example, Congressional Budget Office, *Issues in Designing a Prescription Drug Benefit for Medicare*, October 2002.

¹⁹ Congressional Budget Office cost estimate for H.R. 4954, Medicare Modernization and Prescription Drug Assistance Act of 2002, June 24, 2002.

²⁰ Such an approach was discussed by the National Bipartisan Commission on Medicare Reform and has been the basis for a number of Medicare reform proposals. Marilyn Moon, editor, *Competition with Constraints: Challenges Facing Medicare Reform*, Washington, DC: Urban Institute Press, 2000.

is that the federal subsidies might not keep pace with medical cost increases, so that beneficiaries — and state Medicaid programs — gradually bear a larger share of the total costs through cost-sharing. Moreover, depending on the options available to low-income seniors to select varying options under such a plan, state cost-sharing obligations might rise even if medical price inflation is addressed.²¹ Since Medicaid meets the Medicare cost-sharing requirements for dually eligible beneficiaries, heightened Medicare cost-sharing would further increase state Medicaid expenditures.

Federal Funding for Dual Eligibles. Another option that has been raised is shifting responsibilities for medical care services for dual eligibles from states and the Medicaid program to Medicare. This could simplify program administration since one program — Medicare — would be responsible for all medical benefits for Medicare beneficiaries, including the cost-sharing obligations and coverage of prescription drugs for low-income beneficiaries, although long-term care responsibilities might remain with state Medicaid programs. This might reduce complications that often occur for beneficiaries, health care providers or managed care organizations because of duplicative administration and periodic conflicts in rules between the two programs.²² Administration by the federal government could also make it easier for seniors to gain access to QMB and SLMB benefits, since this could be done more directly in conjunction with Medicare or the Social Security Administration.

A more incremental approach would be to increase federal matching rates for dual eligibles, perhaps to the matching rate used for the State Children’s Health Insurance Program, which would lower state contributions for this population by 30 percent below the current levels. Such an approach could be implemented relatively quickly because it uses existing Medicaid structures and does not require other, large programmatic reforms to be phased in. Increasing the matching rate for dual eligibles would also provide a greater incentive for states to simplify enrollment processes for QMB and SLMB benefits, so that a larger share of seniors could obtain these benefits, for which they are already eligible. This general approach could be further tailored by limiting the increased federal matching rates to a component of the dual eligibles (e.g., QMBs and SLMBs) or to certain services (e.g., prescription drugs or long-term care).

Expansions of Medicare Coverage. In the past, some have proposed incremental expansions in Medicare eligibility, such as expansions for the near-elderly or for disabled people who have not yet met the two-year waiting period for Medicare.²³ Some of the low-income people who would be eligible for Medicare if these expansions were approved are now getting health coverage through Medicaid. Medicare expansions could lower Medicaid expenditures by

²¹ For example, if dual eligibles can select any private health plan regardless of cost-sharing or coverage, they might select plans that increase state Medicaid expenditures. Conversely, if states are permitted to restrict dual eligibles’ choices to the cheapest plans, these Medicare enrollees may be forced into substandard plans, regardless of their preferences.

²² See, for example, U.S. General Accounting Office, *Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*, GAO/HHES-00-94, August 2000.

²³ After people qualify for Social Security Disability Insurance, they must wait two years before gaining Medicare coverage.

shifting part of the costs of the care of these individuals to Medicare, which would become the primary payer for the services that it covers.

Conclusions

The major force driving state Medicaid expenditures higher and higher is the rising costs of care for the aged and disabled, which is strongly affected by the gaps in Medicare coverage for those who are dually enrolled. As a result, Medicaid and the states have shouldered a growing share of the overall public cost of health care for the aged and disabled, while Medicare and the federal government have borne a smaller share.

There is interest in making major changes in Medicare in the coming year. Federal policy-makers traditionally focus on how changes in Medicare policies will affect federal expenditures, Medicare beneficiaries and health care providers. In the coming year, they also should consider how Medicare policy changes will affect states, who are their partners in health care for seniors and people with disabilities covered by Medicaid. Congress could take steps to redress the growing financial burdens that have been placed on state Medicaid programs.

Although changes in Medicare policies can have a profound influence on the long-term financing of Medicaid, it also is important to consider short-term measures that could ease states during the current economic downturn. Fiscal relief measures that temporarily increase federal Medicaid matching rates (and also provide one-time grants to states), could provide stimulus to the economy, while also helping battered states and low-income beneficiaries weather the current economic downturn.