

GAO

Testimony

Before the Committee on the Budget, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Tuesday, April 4, 1995

MEDICAID

Spending Pressures Drive
States Toward Program
Reinvention

Statement of Charles A. Bowsher
Comptroller General of the United States



063229/153913

Mr. Chairman and Members of the Committee:

We are pleased to be here today to provide the Committee current information on the status of the Medicaid program. For years, GAO has looked for opportunities to improve the program's efficiency and to constrain spending growth.¹ We are here to discuss our report on Medicaid spending pressures, which is being released today.² You asked us to examine (1) federal and state Medicaid spending trends, (2) states' efforts to contain Medicaid costs and expand coverage through waivers of certain federal requirements, and (3) the potential impact of the waivers on federal spending.

You and others are currently engaged in a debate over options for cost containment in the Medicaid program, which in 1993 spent \$131 billion. Medicaid growth outpaces that of most major items in the federal budget, including Medicare, and without modification, spending is likely to double in the next 5 to 7 years. Medicaid is also the fastest growing component in most state budgets at a time when states are feeling pressured by many financial constraints and when many are looking for ways to provide care to their uninsured populations.

In response, states are one by one reinventing their Medicaid programs by seeking section 1115 waivers from the Health Care Financing Administration (HCFA), which oversees the Medicaid program. Named for section 1115(a) of the Social Security Act, these waivers free states from certain Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid.

To summarize, requiring states to obtain waiver approval in order to pursue their managed care strategies is burdensome and may hamper their cost containment efforts. Moreover, allowing the waiver process to be used to expand coverage to hundreds of thousands of additional individuals without the consultation and concurrence of the Congress appears inappropriate. The result of these waivers could lead to a heavier financial burden on the federal government.

In this statement I will present a more detailed look at Medicaid's growing expenditures, describe states' efforts to obtain section 1115 waivers, and summarize the expenditure forecast of programs operating with waivers.

¹See appendix I for list of related GAO products.

²Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995). We are also releasing today a related study entitled, Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

MEDICAID CONSUMES GROWING
SHARE OF FEDERAL BUDGET

In 1993, Medicaid spent almost \$100 billion more than it did a decade previously. Currently, Medicaid consumes about 6 percent of all federal outlays--3 times the share devoted to food stamps and 5 times the share devoted to Aid to Families With Dependent Children. The Congressional Budget Office projects Medicaid's annual growth rate at almost 11 percent for the next several years. Medicaid has also grown rapidly in size. In 1993, Medicaid served over 33 million beneficiaries, 11 million more than in 1983.

Creative financing approaches used by states to leverage additional federal dollars contributed to the cost growth in recent years. Part of the approach involved making payments to hospitals that served a disproportionate share of Medicaid and other low-income patients.³ These payments exploded from a few hundred million dollars in 1989 to over \$17 billion in 1992. Although legislation has limited the growth of these payments to disproportionate share hospitals since 1993, the gaming of these payments in some states has both increased the level and affected the distribution of current and future Medicaid spending.

Other factors also worked to increase Medicaid costs: medical inflation, higher utilization of services, and more beneficiaries. Although many of the new beneficiaries were pregnant women and children made eligible by congressional mandates enacted since 1984, the addition of this group played a less significant role in increasing Medicaid costs because these individuals are relatively inexpensive to serve. The pressure on Medicaid costs is expected to continue. For example, the number of individuals with disabilities receiving Medicaid benefits is growing rapidly. While this is a relatively small group, it accounts for a large share of program cost--about two-thirds of Medicaid dollars for one-fourth of the population.

STATES SEEK SECTION 1115 WAIVERS TO
CONTAIN COSTS AND EXPAND COVERAGE

To deal with pressures to contain costs while confronting the problem of the uninsured, a number of states are turning to section 1115 waivers. These waivers address states' needs in two ways: they allow states greater flexibility to test such cost containment strategies as capitated managed care, and they allow states to expand program eligibility beyond traditional Medicaid populations. Since 1993, HCFA has approved for implementation seven statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, and Ohio. Kentucky, Florida, and Ohio have not

³Medicaid: States Use Illusory Approaches to Shift Program Costs to the Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

yet implemented their programs. Another 15 states either have applications pending or have held discussions with HCFA about statewide demonstrations.

These section 1115 waivers allow states to contract with managed care organizations that enroll few or no private patients. In other words, the "75-25 rule" has been waived. This rule stipulates that, to serve Medicaid beneficiaries, 25 percent of a health plan's total enrollment must consist of private-paying patients. The principle behind this restriction is that a health plan's ability to attract private enrollees can serve as one assurance of quality.

The waivers also permit states to require beneficiaries to remain enrolled in their health plans for longer periods of time than Medicaid typically requires. Allowing beneficiaries to choose to disenroll at will, as normally permitted by Medicaid, makes managed care organizations' planning for financial stability difficult and therefore the enrollment of Medicaid beneficiaries less attractive.

Medicaid's restrictions on states' use of managed care reflect historical concerns over quality. In the 1970s, reports on quality of care problems in Medicaid managed care prompted the Congress to enact certain provisions to improve quality assurance. States feel that the 75-25 rule and Medicaid's prohibition against locking enrollees into a plan for an extended period hamper their efforts to contract with managed care networks. While HCFA has agreed to waive some of the traditional requirements aimed at ensuring managed care quality, the terms and conditions of section 1115 waivers require states to operate quality assurance systems and to collect medical encounter data.

In addition to implementing widescale managed care, several states are also greatly increasing the scope of their programs by providing benefits to individuals who would not normally qualify for them. For some demonstrations, states initially estimated high enrollments of newly eligible individuals: 1.1 million in Florida, 395,000 in Ohio, and 500,000 in Tennessee. If coverage expansions similar to these waivers are approved for more and bigger states, the federal government as well as the states could be providing health insurance for millions more beneficiaries.⁴

⁴Increasing Insurance Coverage Through Medicaid Waiver Programs, The Urban Institute (Washington, D.C.: Nov. 1994).

SOME STATES' SECTION 1115
DEMONSTRATIONS COULD INCREASE
FEDERAL SPENDING

Section 1115 waivers, while freeing states to implement managed care cost containment strategies, could in the long run undermine efforts to contain federal expenditures. Our analysis disputes the administration's assertion that all the approved statewide section 1115 demonstrations are budget neutral. It suggests that the granting of additional section 1115 waivers merits further scrutiny for the following reasons:

- The administration is allowing states to apply the federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. The administration and states assume that the enrollment of Medicaid populations in capitated managed care will save states enough money to cover additional low-income people at no extra cost to the federal government. Even if the proposed demonstrations will not require new federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid cost savings (from more aggressive use of capitated care) will not be used to reduce federal spending. At issue is whether or not the federal treasury should benefit from these savings and eligibility be made available for new groups only after congressional debate and legislative action.
- The administration's method for determining budget neutrality may allow states access to more federal funding than they would have received without the waiver. Our initial examination of four states' proposed demonstrations suggests that claims of budget neutrality for these states may not be sustainable in all cases. While Tennessee's demonstration project may be budget neutral, the demonstrations in Florida, Hawaii, and Oregon may require increased financial commitment from the federal government. Relative to overall federal Medicaid spending, the amount of new federal dollars spent in states with approved section 1115 waivers is small. However, the methods used by the administration to assess the budget neutrality of pending and future waiver proposals may greatly affect federal Medicaid spending in the years to come.
- The Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast. A demonstration waiver, granted for a limited period of time, may be a shortsighted approach to reducing states' uninsured populations. If at the end of 5 years the demonstrations have cost much more than estimated, the Congress may face the choice of increasing federal funding or relying on the states to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers.

CONCLUDING OBSERVATIONS

Over 33 million low-income women, children, elderly, blind, and disabled Americans depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the federal deficit under control. Consistent with the Committee's interest in constraining federal spending, states believe they need the flexibility to manage their respective programs. Requiring states to obtain waiver approval in order to aggressively pursue managed care strategies may hamper their cost containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in the absence of these restrictions, continuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses. Finally, we believe that the potential for increased federal spending under future statewide demonstrations warrants close scrutiny of the section 1115 waiver approvals.

* * * *

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Committee members may have.

For more information on this testimony please call William J. Scanlon, Associate Director, at (202) 512-4561. Other major contributors included James Cosgrove, Hannah Fein, Michael Gutowski, and Alfred Schnupp.

RELATED GAO PRODUCTS

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (GAO/IMTEC-93-18, May 13, 1993).

Medicaid Formula Alternatives (GAO/HRD-93-18R, Mar. 31, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

