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HEALTH POLICY BULLETIN

FOCUS: CHANGES IN THE MEDICAID PROGRAM, 1980–91

For the first time, the Medical Services Administration (MSA) in the Michigan Department of Social Services (DSS) has pulled together into one publication information about the Medicaid program that heretofore has not been available in an accessible format. The document was prepared for presentation in late March to the House Appropriations Subcommittee on Social Services.

Designed originally to help poor people gain access to medical care, Medicaid has mutated into a program that serves more and more of the elderly poor and disabled adults. One of the most remarkable characteristics of the program's recipient population is the constancy of the distribution of dollars and recipients: Persons receiving Aid to Families with Dependent Children (AFDC) account for 65 percent of the recipients and 27 percent of the program dollars. This has changed little since 1981. The population receiving Supplemental Security Income (SSI), 15 percent of recipients, accounted for 38 percent of program dollars in 1991. Those receiving Medicaid Only were 14 percent of recipients and 32 percent of program dollars. In other words, fewer than 30 percent of the recipients receive benefits totaling 70 percent of the dollars.

The Medicaid budget is always part of the annual budget shoot-out at the capitol. Its costs are blamed for every budgetary ill that afflicts Michigan. In all the rhetoric, a significant fact is not noticed: Michigan's annual expenses per recipient are well under the national average. The national average in 1991 was $3,001 and Michigan's was $2,283, a difference of $718 per person. In fact, in Region V (the Health Care Financing Administration region that includes Michigan), Michigan has the lowest average payment per recipient. The most popular explanation for Michigan's lower costs is that strict CON regulation of nursing homes leads to lower long-term care costs.

Who gets the Medicaid dollars? Again in 1980 the biggest share went to hospitals (38 percent), but in 1991 hospitals, helped by the special in-patient disproportionate share adjuster payment from hospital voluntary contributions (16 percent), received 52 percent of Medicaid dollars. Nineteen percent of the hospital share is payment for capital, direct medical education, and regular disproportionate share payments. Long-term care declined from 30 percent to 21 percent between 1980 and 1991, and physician services dropped from 15 percent in 1980 to 8 percent in 1991. Pharmacy services stayed the same at 9 percent, while other services, a category that includes items such as payments to HMOs and for dental services, increased from 8 to 10 percent. (The 1991 shares are lower for nonhospital services because of the effect of the hospital voluntary contribution.)

How is the Medicaid dollar divvied up? Pregnancy and newborns claims in 1990 accounted for 40 percent ($214.8 million) of payments made to hospitals in FY 1991. Looking at the distribution of claims for newborns in 1990, one finds that 38.5 percent represented newborns who had problems and required intensive care; the distribution of payments for newborns in 1990 reveals that neonatal intensive care and newborns with problems consumed 82.6 percent of the program's payments for newborns, while normal newborns (61.6 percent of claims) cost the program 17.4 percent of the dollars.

The next largest groups of claims were for respiratory, digestive, and circulatory system ailments, perhaps reflecting the state's unhealthy rankings for chronic diseases. The 32,896 claims in these three categories represent an expenditure of $129.3 million. In-patient mental health and alcohol and drug use services accounted for $1.8 million and 395 claims. (See exhibit.)

Of all the services provided by the Medicaid program, one of the most costly both in dollars and percent of increase is prescription drugs. Medicaid pharmacy payments went from $88.9 million in 1980 to $250.1 million in FY 1991, an increase of 184 percent; although Medicaid pharmacy payments have demonstrated a consistent upward trend, they rose more sharply from 1989 to 1991 than in any other period. One might be tempted to attribute the increase in cost to the number of prescriptions filled; however, the department's data do not bear out that assumption. In truth, while the number of prescriptions filled rose by 13 percent from 1989 to 1991, the average cost per prescription increased by at least 25.8 percent from $14 to almost $18. Medicaid pharmacy professional fees accounted for about 25 percent of the cost of 1989 prescriptions and about 22 percent of the cost of 1991 prescriptions.

Michigan Medicaid's nursing home line increased from $236 million in FY 1980 to $445 million in FY 1991; payments for home health services rose from $2.9 million to $14.1 million over the same period. Although the nursing home line has nearly doubled over same timespan, the cost to the program for home health services is nearly five times greater than it was in 1980.

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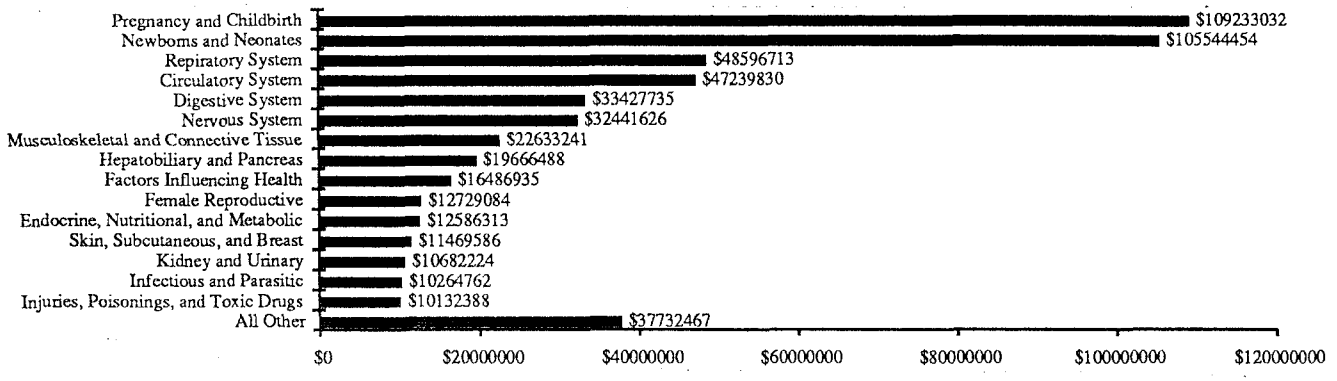
1990 Medicaid In-patient Medical/Surgical Claims Paid Through 9/30/91, by Selected Major Diagnostic Category



SOURCE: Michigan Department of Social Services, Medical Services Administration, March 18, 1992. "All other" category calculated by Public Sector Consultants.
NOTE: These expeditures do not include capital or direct medical education costs. If the costs for AIDS cases were included in the above chart as a separate category, they would rank 14th at $10,371,000. AIDS costs calculated by Public Sector Consultants from data supplied by the Medical Services Administration.

Physician costs have risen from $146.6 million in 1980 to $230.1 million in 1991. Physician visits have declined from a peak of 5.7 visits per year per patient in 1986 to about 5.1 per patient in 1989, a return to about the level of 1982–83.

Changes in the physician fee screen under the Medicaid resource-based relative value scale produced some big winners and losers. The biggest gainers were physicians who provide evaluation and management, obstetrical, and laboratory services. The biggest losers were surgeons. In the case of evaluation and management services, these changes reflect a bias toward cognitive activities rather than procedures. The most significant exception to this is the gain in the value placed on obstetrical services, where the 29-percent increase in the fee screen probably reflects (1) the awareness of the Medical Services Administration that adequate obstetrical care will play a significant role in reducing the dollars spent on newborns with problems and neonatal intensive care, and (2) the fact that low Medicaid physician fee screens had a devastating effect on access to obstetrical services.

One of the most interesting graphics in the MSA document shows the relationship between Medicaid eligibles and expenditures from 1980 to 1991. While the number of eligibles was 927,000 in 1980 and 1,067,000 in 1991, an increase of 7.2 percent, expenditures rose 175.6 percent to $2.7 billion. (A large chunk of this increase is represented by the special $439-million hospital voluntary contribution program in 1991.)

We thought it might be instructive to compare the increase in Michigan Medicaid costs from 1980 to 1991 with the increase in total national health care expenditures over the same period, so we calculated the change in national health care expenditures from 1980 to 1991 and found that national health care expenditures increased 193.3 percent. While Michigan Medicaid expenditures have risen tremendously, the increase of 175.6 percent is slower than that of national health care expenditures.

What about the effect of managed care plans on Medicaid? Seven of the state's eighteen health maintenance organizations (HMOs) serve Medicaid recipients, six in southeast Michigan and one in Flint. Since enrollment in managed care plans began in 1983, upward trends in HMO and Physician Sponsor Plan (PSP) enrollment have been fairly consistent; the base year of 1983 saw about 4,000 people enrolled in PSPs and about 75,000 in HMOs. Estimates indicate that enrollment in PSPs and HMOs will reach 120,000 and 175,000, respectively, this year. Thus, slightly more than 25 percent of Medicaid recipients will be in either PSPs or HMOs in 1992.

OF INTEREST

The legislature has adjourned for its spring break; the Senate returned April 21, and the House will return on April 28.

The House Committee on Public Health expects to take up and report out the following bills by April 30:

- HB 5296, staffing in nursing homes
- HB 5298, nursing home delicensure
- HB 56 23, certificate of need reform
- HB 5621, capital pass-through
- HB 5152, utilization review

—Frances L. Faverman, Editor

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