



Trends in Medicaid Enrollment and Spending in Missouri, 2011-2016

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Introduction

Although Missouri chose not to expand Medicaid under the Affordable Care Act (ACA), MO HealthNet (Missouri Medicaid) does provide benefits to a large portion of the population. MO HealthNet currently covers over 990,000 Missouri residents, representing 11% of the population.^{1,2} Enrollment increases since the ACA's passage have contributed to a drop in the uninsured rate in Missouri from 13.0% in 2013 to 9.8% in 2015.³ Since January 2014, MO HealthNet enrollment has grown by nearly 150,000, with children accounting for over 82% of this enrollment growth and 44% of total enrollment.⁴ It is important to examine Missouri enrollment and expenditure increases by category over time in order to understand the potential impact of redesigning Medicaid funding as a block grant or per-capita cap system.

The current strain on the state and federal budgets created by Medicaid is due in part to income inequality having increased substantially in the U.S. over the past 40 years.⁵ Particularly in Missouri, income has become more concentrated among the wealthiest of individuals. The share of all income held by individuals with incomes in the top 1% rose from 9.6% in 1979 to 17.6% in 2009.⁶ Research has linked such income inequality to negative and costly health outcomes such as diabetes, obesity, stroke, high cholesterol, and hypertension.⁷ Receiving Medicaid coverage helps decrease health disparities by improving access to care and self-reported health.⁸ Further, when individuals do not have access to insurance, necessary medical care is often postponed and medical debt increases, which leads to greater health disparities and income inequality.⁹ In fact, research has shown that the Medicaid program significantly decreases levels of income inequality in the U.S.¹⁰

Key Findings

- Medicaid spending by eligibility group is not proportional to enrollment. Blind and disabled individuals represent only 16% of enrollment but account for 47% of spending. Children, who represent over half of enrollment, account for just 25% of expenditures.
- Between 2011 and 2016, expenditures in the eligibility categories of the aged, pregnant women, and blind and disabled persons have grown substantially faster than in the adult and child categories.
- Child beneficiaries tend to comprise a larger share of a county's Medicaid population in urban counties and a smaller share in rural counties of Missouri. The opposite is true for aged, blind, and disabled beneficiaries, who tend to make up a larger share of Medicaid enrollment in rural areas like southeastern Missouri.
- If a per capita cap had been implemented in 2005 with a commonly proposed growth rate, the estimated shortfall per blind and disabled beneficiary in 2015 would have been \$5,623, or 23% of the current spending per blind and disabled enrollee. The approximate shortfall per adult beneficiary would have been \$3,437, or more than 50% of current spending per adult enrollee.

Data and Methods

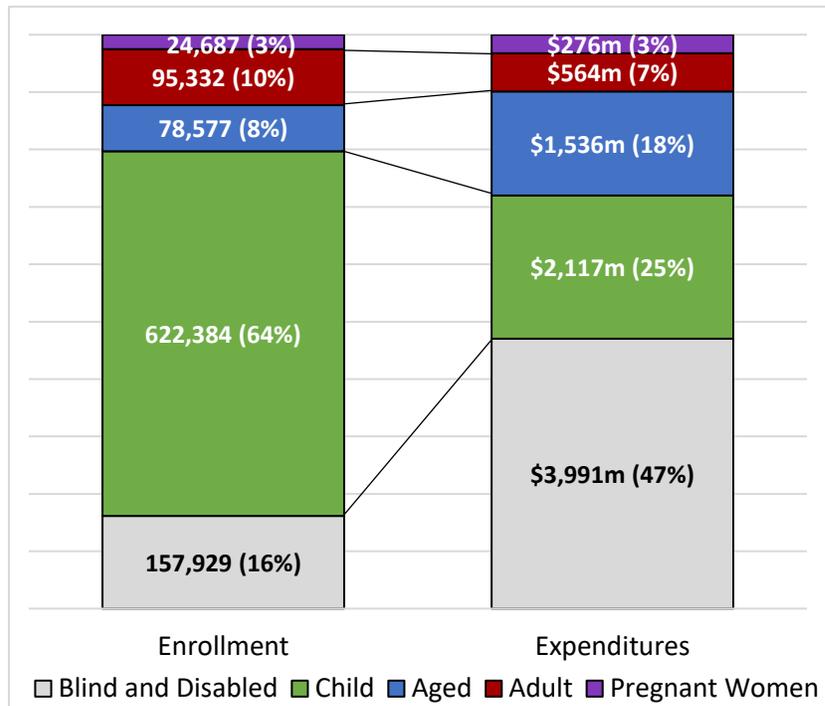
Data on MO HealthNet overall expenditures, overall enrollment by eligibility group, and county-level enrollment by eligibility group were retrieved from Missouri Department of Social Services' monthly management reports.¹¹ Per capita spending by eligibility group for the state was calculated by dividing overall calendar year expenditures for each group by average calendar year enrollment. Overall county-level expenditures and enrollments for calculating per capita spending by county were also retrieved from Missouri Department of Social Services.¹²

Results

In FY 2017, Missouri managed a budget of approximately \$8.2 billion of combined federal and state Medicaid funds.¹⁰ Forty-eight percent of this \$8.2 billion (approximately \$3.8 billion) represents the state's contribution to the Medicaid program, which accounts for 30% of Missouri's total budget in FY 2017.¹⁰ Missouri receives matching funds from the federal government for Medicaid expenditures. Its Federal Medical Assistance Percentage (FMAP) of 63.2% means that, for each \$1 Missouri spends, the federal government contributes \$1.72 to the MO HealthNet program.¹³ Also, about 23% of the program budget comes from provider taxes.¹³

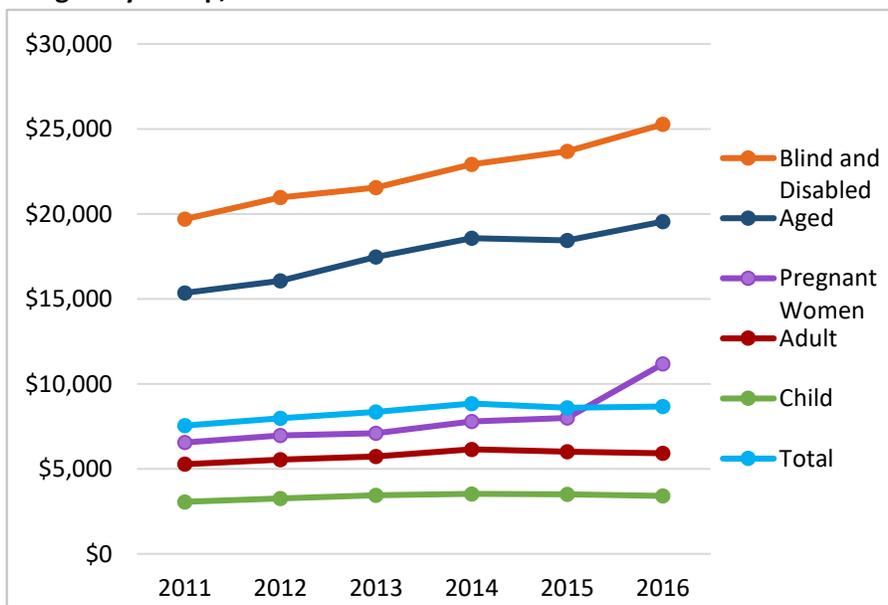
In 2013, Missouri was ranked ninth in per capita spending per full-benefit enrollee out of 46 states and the District of Columbia.¹⁴ While spending per enrollee in Missouri is high relative to other states, the majority of Medicaid spending is allocated to Missouri's most vulnerable citizens. Children and the blind and disabled population accounted for 72% of MO HealthNet expenditures in CY 2016.¹⁰ However, enrollment by eligibility category is not proportionate to spending (Figure 1). The blind and disabled accounted for approximately 47% of expenditures but only 16% of total enrollment. In contrast, children accounted for 64% of total enrollment but only 25% of expenditures.

Figure 1. Missouri Medicaid Enrollment and Total Expenditures by Eligibility Group, CY 2016



Source: Missouri Department of Social Services. Monthly management reports (2016) retrieved from: http://dss.mo.gov/re/fsd_mhdmr.htm

Figure 2. Missouri Medicaid Average Per Capita Expenditures by Eligibility Group, CY 2011-2016

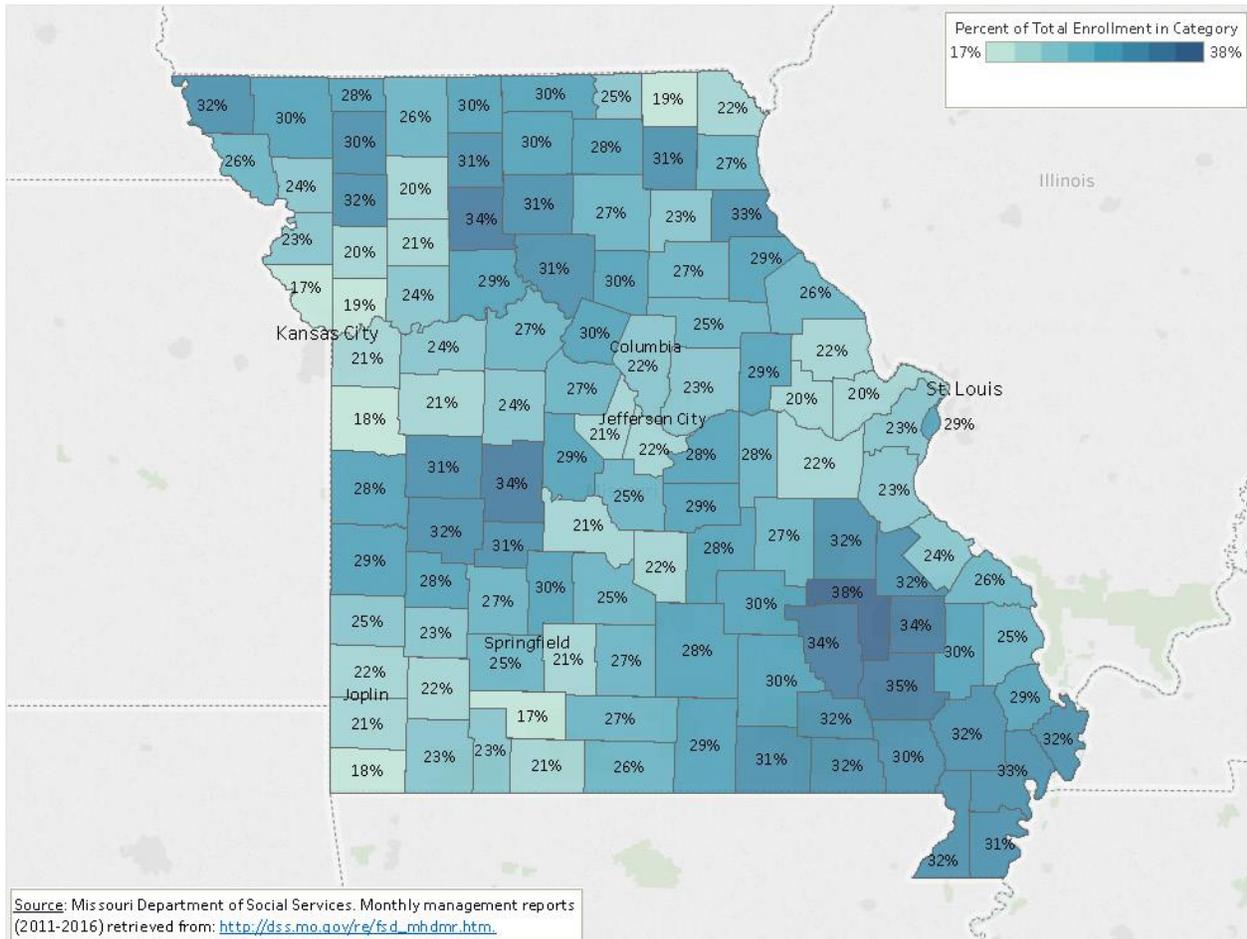


Differences in spending trends by eligibility category also occur in per capita spending. Figure 2 shows growth in per capita spending by eligibility group between 2011 and 2016. In CY 2016, per capita spending on the blind and disabled was over 7 times higher than per capita spending on children. However, for children and adults, per capita spending has been steady over recent years.

Figure 2 also shows that there was an increase in spending per capita for all eligibility groups between 2011 and 2016.

Spending per capita for the aged, the blind and disabled, and pregnant women grew rapidly over time. In contrast, per capita spending on adults and children grew more slowly. Although growth differed across groups, the growth in all of the eligibility categories' per capita spending outpaced inflation in medical care, as measured by the U.S. Medical Consumer Price Index (CPI-M) between 2011 and 2016. Specifically, in the blind and disabled, aged, and pregnant women eligibility groups, per capita expenditures grew by an average of 5%, 5%, and 12% per year, respectively, while CPI-M only grew by an average of 3% annually.

Figure 3. Percent of Medicaid Enrollment by County in Aged, Blind, and Disabled Category



There is also significant geographic variation in Medicaid enrollment by category and associated expenditures. Figure 3 illustrates that the percentage of overall Medicaid beneficiaries who are aged, blind, or disabled (ABD) is often higher in rural parts of the state – in particular, in southeast Missouri. In contrast, more densely populated counties have a lower share of ABD individuals in their Medicaid population.

In general, children’s share of enrollment follows the opposite pattern of the ABD share of enrollment, as shown in Figure 4 below. In rural areas children enrolled in Medicaid comprise a smaller share of Medicaid in each county than in urban areas. This is particularly true for the highly rural counties in southeastern Missouri. In contrast, the more urban counties in Missouri tend to have a greater percentage of their overall Medicaid enrollment in the child category.

Figure 5 displays county-level data on per capita Medicaid spending. There is a relationship – although it is not always consistent – between per capita spending and child enrollment. In general, counties with a high

Figure 4. Percent of Medicaid Enrollment by County in Child Category

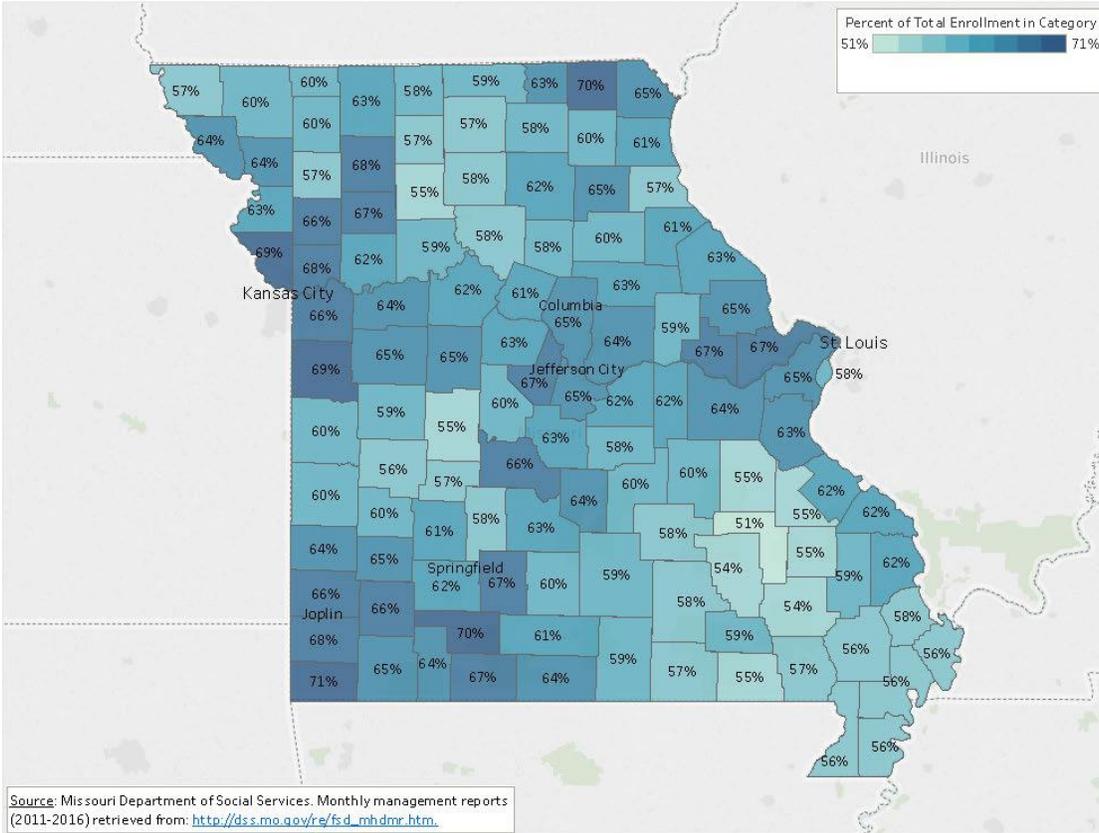
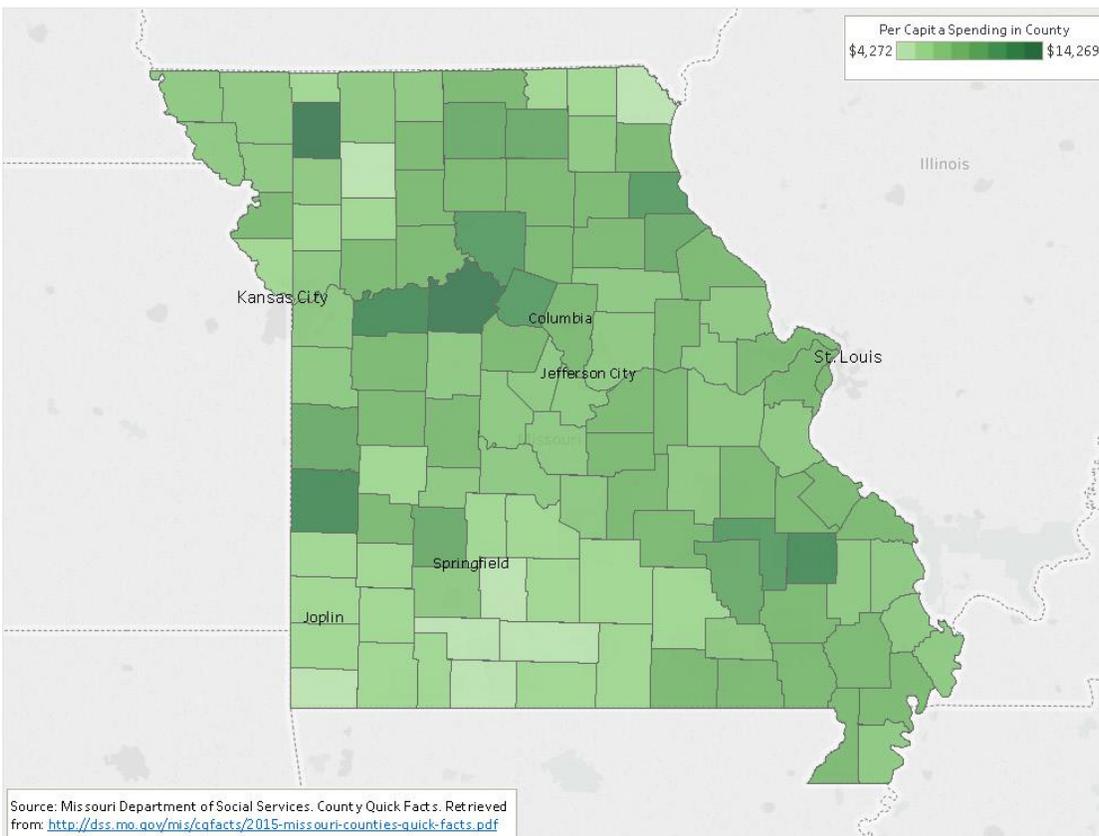


Figure 5. Per Capita Medicaid Spending by County



percentage of child enrollees tend to have lower per capita spending. This is true especially for counties in the southwestern portion of the state. In contrast, the areas of southeastern Missouri with lower percentages of children tend to have higher per capita spending. However, ABD enrollment is only somewhat correlated with per capita spending. For example, St. Louis and St. Charles counties, which have high percentages of child beneficiaries and low percentages of ABD beneficiaries, also both have relatively high per capita spending.

Discussion

Recently, in Missouri as well as at the federal level, block grants or per capita caps have been proposed as a way to reform or restructure the funding for state Medicaid programs. Reforming the Medicaid funding structure in either of these ways is likely to have a significant impact on the amount funding that states receive for their Medicaid programs from the federal government. The parameters of such reforms have not been clearly defined at this time; the specific choices made will do much to determine whether states will maintain or improve their ability to adequately care for all of their existing and potential Medicaid beneficiaries.

Both of these types of Medicaid funding reform have the potential to reduce federal Medicaid funding for states over time. A block grant that allocates a set amount of funds to the states will likely not adjust to changes in Medicaid enrollment, such as in the case of economic recession, potentially leaving states to care for a growing number of Medicaid beneficiaries with limited resources. It also will not account for any increased enrollment in the costlier populations that may stem from demographic changes.

A per capita cap is less problematic, but it still creates budget concerns. Figure 2 shows that the rate that MO HealthNet expenditures increase varies substantially by eligibility group. If a per capita cap system were to specify a cap that grows at the same rate for all eligibility groups, the groups whose expenditures tend to grow more quickly may leave the state with a funding shortfall. For example, if a per capita cap had been implemented in 2005 with a growth rate of Medical Consumer Price Index (CPI-M) plus 1 percentage point, as is commonly proposed, the estimated shortfall per blind and disabled beneficiary in 2015 would have been \$5,623, or 23% of the current spending per blind and disabled enrollee. The approximate shortfall per adult beneficiary would have been \$3,437, or more than 50% of current spending per adult enrollee.^{15,16}

In response to such shortfalls, Missouri would have had to either make up for these deficits from the state budget, and/or cut benefits, provider reimbursements, or eligibility levels. Given that the distribution of eligibility groups and current spending levels is not uniform across the state, this hypothetical per capita cap would have necessitated difficult coverage tradeoffs across the state's geographic regions.

Despite the fact that these Medicaid funding reforms are being proposed in an effort to control the growth of Medicaid spending in budgetary terms, ultimately, the implementation of a block grant or per capita cap in Missouri may not lead to significant overall healthcare cost reductions for Missouri's economy. Cutting benefits, provider reimbursements, or reducing eligibility levels altogether would likely result in individuals having less effective coverage or no coverage at all. As a consequence, they could postpone care because of costs and eventually be admitted to hospitals sicker than they would have been if they had received preventive care.¹⁷ This scenario would increase uncompensated care costs to be borne by hospitals and clinics serving uninsured populations, offsetting many of the cost savings that could occur through implementation of a block grant or per capita cap. If the state works to improve access to care for older adults under the age of 65, this could halt the trend depicted in Figure 2, decreasing the size of future aged and blind and disabled populations, and thereby reducing costs.

To achieve long-term sustainable cost savings, it is necessary to understand the factors driving cost growth in different subpopulations, which may include additional research into the social determinants of health. Access to preventive and acute care for all low-income individuals can, as such, be regarded as an investment in the economic health of the state. Ultimately, without addressing the underlying health effects resulting from income inequality, cost reduction will be difficult in the long run.

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