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M E M O R A N D U M

November 17, 2016

TO: Interested Persons

FROM: Kate Watkins, Senior Economist, 303-866-3446

SUBJECT: Medicaid Trends and Cost Drivers

Summary

This memorandum provides information on recent trends in Medicaid caseload growth and drivers of state Medicaid expenditures. Included in this memorandum is a ten-year history and three years of projections for Colorado Medicaid caseloads, government expenditures, and expenditures per Medicaid enrollee. A summary of the factors that have historically driven growth in state Medicaid expenditures is also included.

Background

Medicaid is a means-tested entitlement program that finances the delivery of certain health care services, including primary, acute, and long-term care. While states are responsible for administering Medicaid programs, funding is shared between the federal and state governments at varying rates, called the federal medical assistance percentage (FMAP). The FMAP for any given state reflects the federal government share of funding for most Medicaid enrollees. The share ranges from 50 percent to 83 percent of total funding across states. Historically, Colorado's FMAP has been just over 50 percent for most Medicaid enrollees and is expected to remain just over 50 percent for the current and next fiscal year. Some Medicaid populations receive a higher federal share of funding.

State participation in Medicaid is voluntary. Currently all states, the District of Columbia, and all U.S. territories are participating in the program. States are entitled to receive federal funding for Medicaid if they meet certain federal requirements.[1] Effective June 27, 2016, Colorado's Medicaid program is called Health First Colorado.

[1] 42 U.S.C. § 1396 (a).

Colorado eligibility requirements. Coloradans may qualify for Medicaid if they meet certain eligibility requirements determined by statute. Eligibility for most Medicaid populations is expressed as a percentage of the federal poverty level (FPL) guidelines. Some populations may also qualify based on other criteria, such as eligibility for federal Supplemental Security Income (SSI) and level of disability. Table 1 summarizes the FPL guidelines for 2016 for selected Medicaid populations.

Table 1
Medicaid Income Guidelines, Maximum Monthly Income
Effective April 1, 2016

Family Size	Adults 133% FPL*	Children 142% FPL*	Pregnant Women 195% FPL*
1	$1,317	$1,406	$1,931
2	1,776	1,896	2,604
3	2,235	2,386	3,277
4	2,694	2,876	3,949
5	3,153	3,366	4,622
6	3,611	3,856	5,295
7	4,071	4,347	5,969
8	4,532	4,839	6,645
9	4,994	5,331	7,321
10	5,455	5,824	7,997

Source: Department of Health Care Policy and Financing.
FPL = Federal Poverty Level.
*The effective percentage of FPL may be higher for some individuals based on the modified adjusted gross income (MAGI) calculation, which excludes certain income.

Income thresholds are based on combined family income. In some instances, not all family members will qualify for Medicaid. For example, in a family with two adults and two children with an income of between 133 percent and 142 percent FPL, only the children will qualify for Medicaid. Similarly, if a pregnant woman has a spouse and other children, she may qualify, while her spouse and children may not qualify if the family's combined income exceeds the income thresholds for adults or children.

Table 2 summarizes the eligibility requirements for all Colorado Medicaid populations and recent eligibility expansions. Notable legislation includes House Bill 09-1293, which expanded eligibility for most Medicaid populations, and created a new mechanism to fund the eligibility expansions and increased reimbursement rates to health care providers through the creation of the Hospital Provider Fee.

Additionally, the federal Patient Protection and Affordable Care Act (ACA) of 2010 allows states to increase the upper income limit for eligibility for most Medicaid populations and to receive an enhanced federal match to partially fund the expansion. Colorado expanded eligibility to the ACA upper limit, primarily under Senate Bill 13-200.

Table 2
2016 Colorado Medicaid Eligibility Requirements and Recent Expansions

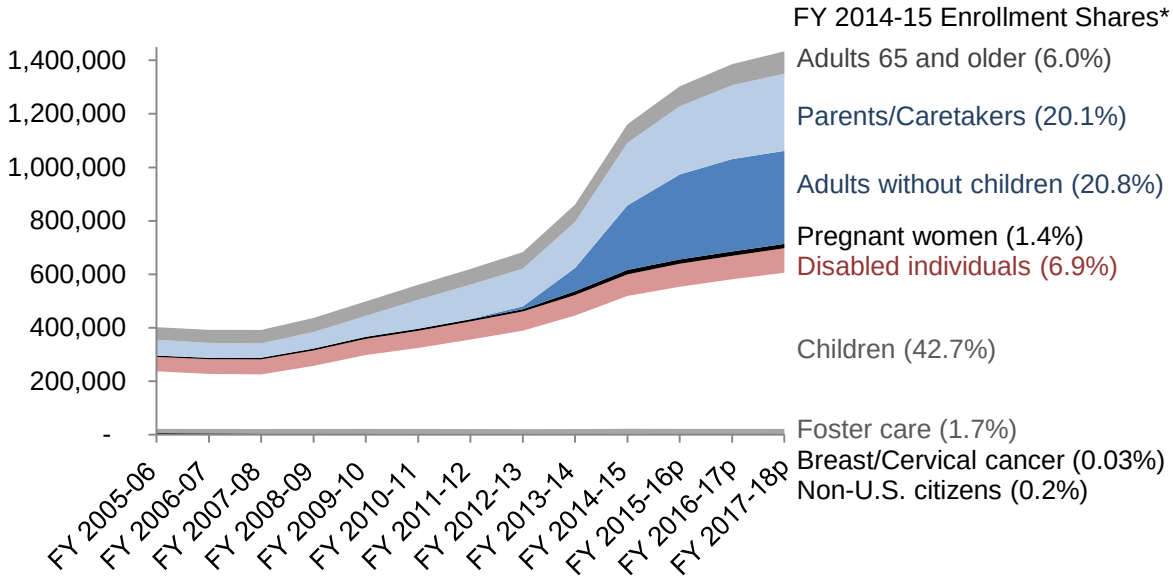
Population	Eligibility Requirements* and Recent Eligibility Expansions
Adults	
Over age 65	*Current threshold*: Qualification for SSI,** or income up to 133% FPL. Some individuals may be "dual-eligible" for both Medicaid and Medicare.
Parents/Caretakers	*Current threshold*: Income up to 133% FPL. *Recent expansions*: HB 05-1262 extended eligibility to 68% FPL; HB 09-1293 expanded eligibility to 100% FPL, and SB 13-200 expanded eligibility to 133% FLP.
Ages 19 to 64 without dependent children	*Current threshold:* Income up to 133% FPL. *Recent expansions:* HB 09-1293 expanded eligibility to a capped number of enrollees. Beginning in 2014, the enrollment cap was lifted.
Pregnant women	*Current threshold:* Income up to 195% FPL. *Recent expansions:* SB 11-250 increased eligibility from 133% to 185% FPL. Subsequent federal adjustments increased the threshold to 195% FPL.
Disabled individuals	
Up to age 64	*Current threshold:* Qualification for SSI,** or income up to 133% FPL for adults and 142% FPL for children under age 19.
Medicaid "buy-in"	*Current threshold:* If not otherwise qualified, working adults with a qualifying disability and incomes of up to 450% FPL may "buy-in" to Medicaid. Similarly, children with a qualifying disability and family income of up to 300% FPL may "buy-in" to Medicaid. Premiums are adjusted based on a sliding scale. *Recent expansions:* The buy-in program was established by HB 09-1293.
Children	
Under age 19	*Current threshold:* Income up to 142% FPL. *Recent expansions:* SB 11-008 expanded eligibility to children of all ages with family incomes up to 142% FPL. Prior to SB 11-008, for children ages 6 to 18, eligibility was limited to those with family incomes up to 100% FPL. Pursuant to HB 09-1293, enrolled children receive continuous eligibility for 12 months.
Foster care	*Current threshold:* Eligible regardless of income up to age 26. *Recent expansions:* Federal law requires automatic enrollment up to age 18. SB 07-002 and SB 08-099 extended eligibility through age 20. The federal ACA expanded the age to 26.
Other populations	
Breast and cervical cancer patients	*Current threshold:* Women ages 40 to 64, uninsured and otherwise not eligible for Medicaid, with income up to 250% FPL (authorized by SB 01S2-012).
Non-U.S. citizens	*Current threshold:* Qualify for emergency services only and must otherwise meet Medicaid eligibility criteria.

Source: Colorado Department of Health Care Policy and Financing, FY 2016-17 Budget Request, Caseload Narrative; and Sections 25.5-5-101 (1), 25.5-5-201 (1), 25.5-5-205 (3), 25.5-5-206 (1), and 25.5-5-308 (1), C.R.S.
FPL = Federal Poverty Level. SSI = Supplemental Security Income.
*The effective percentage of FPL may be higher for some individuals based on the modified adjusted gross income (MAGI) calculation, which excludes certain income.
**SSI eligibility requires monthly income of less than $733 for individuals, or $1,100 for couples. Those who meet the nursing facility level of care may be eligible with incomes up to 300 percent of these amounts.

Medicaid Caseload and Expenditure Trends

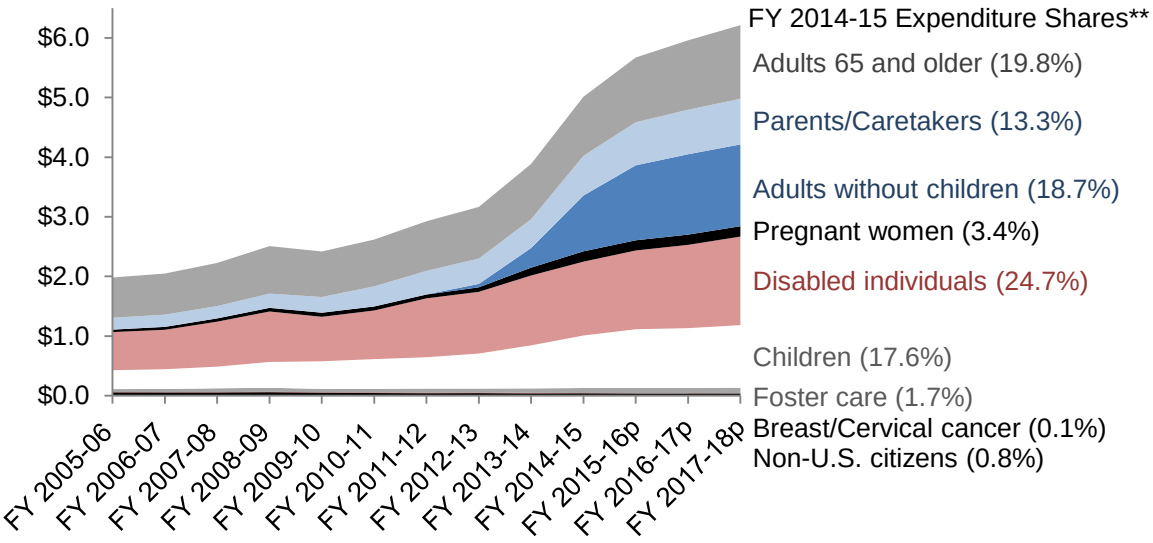
Figures 1 through 3 provide a ten-year history and three years of projections for Colorado Medicaid enrollment, total expenditures, and expenditures per enrollee, respectively.

Figure 1
Historical and Projected Medicaid Enrollment



Source: Colorado Department of Health Care Policy and Financing, February 2016 projections.
p = Projection. *FY 2014-15 enrollment shares by population shown in parentheses.

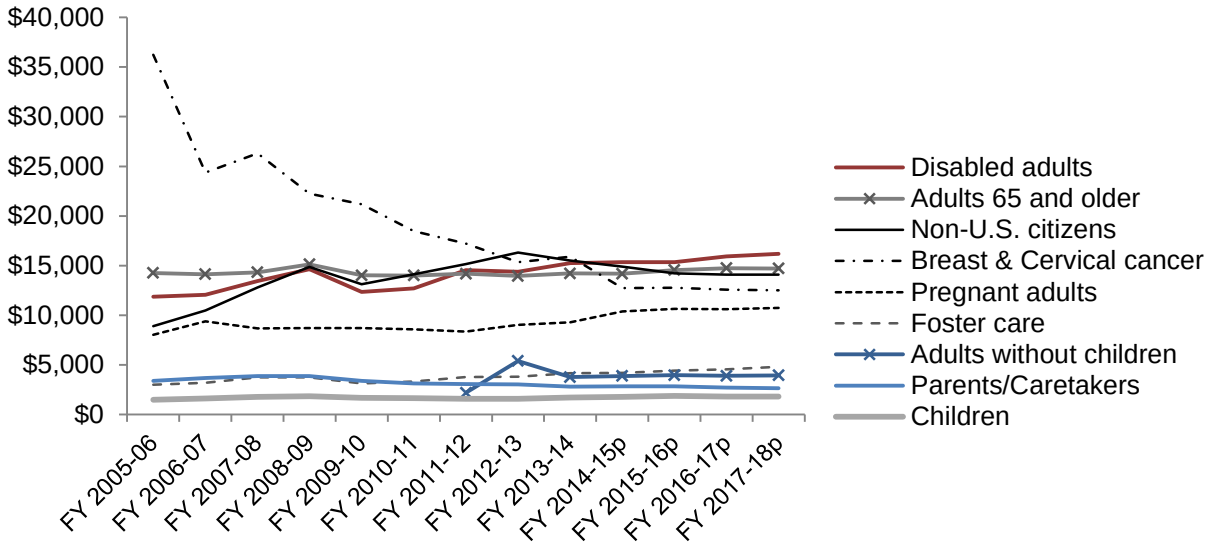
Figure 2
State and Federal Medicaid Expenditures by Population*
Dollars in Billions



Source: Joint Budget Committee Staff. p = Projection. *Amounts exclude supplemental payments to providers and financing mechanisms. **FY 2014-15 expenditure shares by population shown in parentheses.

Medicaid expenditures have increased as a result of rising enrollments and higher costs for health care, among other factors detailed in the section that follows. Adults over age 65 and disabled individuals are among those with the highest average expenditures per enrollee, as these populations tend to have greater medical needs. Expenditures are also relatively higher for non-U.S. citizens receiving emergency care and participants of the breast and cervical cancer program. These latter two populations represent very small shares of total Medical enrollees and total expenditures.

Figure 3
State and Federal Expenditures per Medicaid Enrollee*



Source: Colorado Department of Health Care Policy and Financing, February 2016 projections; and Joint Budget Committee Staff. p = Projection. * Amounts exclude supplemental payments to providers and financing mechanisms.

Medicaid Cost Drivers

Factors that have historically driven growth in Medicaid expenditures are summarized briefly below. Generally, drivers of the state's share of Medicaid costs can be broken down into three categories: enrollment drivers, direct services cost drivers, and cost shifting to patients and the federal government.

Enrollment drivers include the following:

- ***Eligibility expansions***. As detailed above, recent legislation has expanded eligibility for Medicaid to a larger population. Historically in Colorado, some expansions have been prompted by federal legislation such as the federal ACA, which allowed the state to draw down additional federal matching funds using the Hospital Provider Fee funding mechanism.

- ***Economic factors***. Economic conditions are a significant driver of Medicaid caseload growth, as Medicaid eligibility for most populations is based on income. An increase in the number of unemployed individuals living in Colorado, or a reduction in household

income may result in higher enrollment, as was the case following the 2007-09 recession.

- ***Demographic factors***. Medicaid caseloads rise with growth in the Colorado population, which is expected to average 1.7 percent growth annually in coming years, based on the state demographer's November 2016 projections. The aging of Colorado's population is also expected to contribute to growth in Medicaid expenditures. The population of those over age 65 is projected to grow at an average annual pace of 4.7 percent over the next three years. This population has significantly higher average medical costs relative to most other eligible populations.

Direct service costs that influence state Medicaid expenditures include the following:

- ***Health care benefits offered.*** The federal ACA requires that state Medicaid programs cover certain services, including primary and specialty care, hospitalization, prescription drugs, medical equipment, and emergency and urgent care, among others. Some benefits are optional and states may determine whether or not they are offered. For example, Colorado added a new adult dental benefit of up to $1,000 in dental services per fiscal year starting July 1, 2014. Expansions or reductions in the benefits offered, including services and/or prescription drugs and medical equipment, could result in higher or lower state Medicaid expenditures. Though notably, some benefits, such as telemedicine or preventative care, may result in higher short-term costs but greater long-term savings.

- ***Rising health care costs.*** The cost of most health care services have risen considerably over time, outpacing inflation for most other goods and services, and contributing to higher state Medicaid expenditures. According to data published by the U.S. Bureau of Labor Statistics, the prices consumers pay for medical care in the U.S. rose 32.9 percent over the ten-year period between 2006 and 2015. In Colorado, medical care prices rose 39.7 percent over the same period. Comparatively, inflation for all price components rose 17.6 percent and 21.4 percent for the U.S. and Colorado, respectively, over the past ten years.

- ***Provider reimbursement rates***. States may increase (or reduce) Medicaid expenditures by increasing (or reducing) reimbursement rates to health care providers for the medical goods and services they provide to Medicaid patients. In Colorado, reimbursement rates are determined by the Department of Health Care Policy and Financing with the assistance of the Medicaid Provider Rate Review Advisory Committee (MPRRAC).[2]

Finally, state Medicaid expenditures depend on the extent to which states shift or share health care costs with patients and the federal government.

- ***Patient premiums and copayments.*** Premiums are generally not allowed for Medicaid beneficiaries with incomes at or below 150 percent FPL. Some exceptions exist, including Medicaid "buy-in" programs, which often require premiums based on a sliding income scale. Co-payments are another method for sharing the cost of health care with patients. In Colorado, co-payments are currently determined by rule and are required for

[2]The MPRRAC was created under Senate Bill 15-228 and operates in accordance with the Colorado Medical Assistance Act (Section 25.5-4-401, C.R.S.).

certain services and prescription drugs. Selected populations are currently exempt from copayments, including children and pregnant women.[3]

The federal ACA includes a provision to increase Medicaid payment rates for primary care services to an amount equal to Medicare rates in calendar years 2013 and 2014. The federal government funded the difference between rates for these two years, based on state Medicaid rates as of July 1, 2009. Colorado maintained the rate "bump" with some modifications though FY 2015-16. The bump is expected to end this year based on the current budget for FY 2016-17.

- ***Federal funding***. States may take certain measures to maximize available federal funding. For example, in Colorado, the hospital provider fee provides a mechanism to draw down additional federal dollars. Federal funding covers just over 50 percent of eligible health care costs for most Medicaid enrollees, while some Medicaid populations receive a higher federal share of funding, including Child Health Plan Plus (CHP+) enrollees, and breast and cervical cancer program participants, among others.

  The federal ACA provides enhanced federal funding for enrollees newly eligible under the expansions of the act. For these Medicaid expansion populations, federal funding covered 100 percent of eligible health care costs through 2016. Federal funding decreases to 95 percent in 2017, and continues to decrease incrementally each year until it reaches 90 percent in 2020.

[3]For additional information regarding co-payments, visit the Department of Health Care Policy and Financing's website: https://www.colorado.gov/pacific/hcpf/colorado-medicaid-co-payments.