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## Forecast of Medicaid Caseloads and Expenditures Before The House Finance and Appropriations Committee For The FYs 2004-2005 Biennial Budget

*Chuck Phillips, Division Chief*

*February 4, 2003*

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Good afternoon, Mr. Chairman and Members of the House Finance and Appropriations Committee. My name is Chuck Phillips. Today I will be presenting the Legislative Service Commission's baseline forecast for Medicaid caseloads and expenditures.

Medicaid has many funded programs within the state budget including waiver programs such as PASSPORT and others designed to provide care in a home- or community-based setting. To the extent that these programs allow people to avoid institutionalization, they also divert expenditures from line item 600-525, Health Care/Medicaid, to other places within the state budget. These waivers are growing pieces of Ohio's medical assistance for low-income individuals, and should be seen as a part of the overall medical care policies and expenditures for the state. However, expenditures for these waiver programs are capped at the level at which they are appropriated. In contrast, traditional Medicaid is an entitlement program. In other words, the state must provide federally mandated services to all those who meet the eligibility criteria. Therefore, in order to get an idea of what level of appropriations will be needed to fund the traditional Medicaid program in Ohio, we forecast the caseload and expenditures each biennium.

### Caseloads

The total number of persons eligible for Medicaid grew by approximately 11 percent from 1.28 million in FY 2001 to 1.42 million in FY 2002. The total number of eligibles is estimated to reach 1.56 million in FY 2003, approximately a 10 percent increase over FY 2002. LSC forecasts that the number of persons eligible for Medicaid will continue to

grow to 1.64 million in FY 2004 and 1.65 million in FY 2005, approximately a 5 percent and 1 percent increase, respectively.

Poor labor market conditions associated with the recession have been the primary driving force behind the growth in total caseload. An additional factor behind the recent growth in caseload has been the CHIP-II program expansion that began on July 1, 2000. The CHIP-II program covers uninsured children under age 19 in families with incomes between 150 percent and 200 percent of the Federal Poverty Guideline (FPG). The eligible population for CHIP-II grew by slightly over 90 percent in FY 2002, and is forecast to grow by approximately 18 percent in FY 2003, as the process of enrolling those made newly eligible under the expansion reaches its conclusion.

LSC forecasts that the overall Covered Families and Children (CFC) caseload, which includes Healthy Families, Healthy Start, CHIP-I, and CHIP-II will peak in the fourth quarter of FY 2004, and begin to drop in the second quarter of FY 2005 as the economy begins to recover.

CFC eligibles access their health care benefits through either the traditional fee-for-service system or the Medicaid managed care program. The Medicaid managed care program has three different enrollment categories: mandatory, voluntary, and preferred option. In FY 2001, the state introduced the preferred option. Under preferred option, recipients are automatically enrolled in managed care if they fail to select the traditional fee-for-service. This policy change has pushed up the HMO penetration rate from approximately 28 percent in FY 2001 to 32 percent in FY 2002. LSC's baseline forecast assumes that the take up effect of the preferred option program will diminish in FY 2003, and projects the HMO penetration rate will be approximately 35 percent for FY 2004 and FY 2005.

Growth in the Aged, Blind, and Disabled (ABD) caseload accelerated in FY 2002 and continued into the first half of FY 2003. The acceleration was driven by the disabled subcategory of the ABD category. The accelerated growth in the disabled subcategory is projected to continue through the end of FY 2003, after which the growth rate is projected to gradually return to a more typical historical rate.

### Costs

Medicaid program costs are estimated separately for each of the nine major expenditure categories: long-term care (nursing facilities and Intermediate Care Facilities for the Mentally Retarded), hospitals (inpatient and outpatient), physician services, prescription drugs, health maintenance organizations (HMOs), Medicare buy-in, waiver, all other care, and DA Medical. After forecasting changes in the caseload, a cost per Medicaid recipient is projected. The cost per recipient is itself broken down into two components: the average number of claims per recipient, called the "utilization rate," and the average cost per claim submitted. The average cost per claim depends heavily on overall health care

inflation -- Medicaid spending on health care services that are market driven significantly outweighs program payments to providers that are tied to fee schedules. In addition, payment rates for long-term care, inpatient hospital care, and prescription drugs are statutorily connected to market place trends. Consequently Medicaid, like any other third party payer, is very susceptible to market forces.

I will briefly highlight our forecast of costs for the three largest Medicaid expenditure categories: nursing facilities, hospitals, and prescription drugs. These three categories combined represent approximately 74 percent of total Medicaid spending in the 600-525 line item.

Payments to nursing facilities are based on cost reports. Nursing facilities annually submit cost reports to JFS, which are used to calculate facility-specific per diems for the following state fiscal year. The per diem rates are then adjusted quarterly to account for differences in each resident's needs -- known as the "case-mix adjustment." The average per diem in FY 03 for nursing facilities is projected to grow by approximately 6 percent to \$152.29. The average per diem in FY 2004 and FY 2005 is projected to grow by approximately 5 percent to \$159.56 and an additional 5 percent to \$167.94, respectively. The rise in the per diem is fueled by heightened acuity levels, increased capital costs, and to a larger extent, elevated direct care costs. Estimated expenditures for nursing facilities are approximately \$2.76 billion in FY 2004 and \$2.95 billion in FY 2005.

The growth rate in spending for hospital care is projected to be approximately 10 percent from FY 2003 to FY 2004, and 8 percent from FY 2004 to FY 2005. Estimated expenditures for inpatient and outpatient hospital services are \$1.97 billion in FY 2004 and \$2.12 billion in FY 2005. The Ohio Administrative Code requires an annual inflationary update to inpatient rates; however, outpatient rates are based on a fee schedule that is not automatically inflated.

S.B. 261 of 124<sup>th</sup> General Assembly authorizes JFS to establish a supplemental drug rebate program under which drug manufacturers may be required to provide a supplemental rebate to the state as a condition of having their products covered by Medicaid without prior approval. The bill also allows the Director of JFS to apply for a federal Medicaid waiver, if necessary, to establish the program. It is expected that this program will be implemented in the coming biennium. LSC assumes that this policy will affect the growth rates for cost-per-claim, as well as drug utilization and thus forecasts that the growth rates for cost-per-claim and utilization ratio will decelerate and hold constant for FY 2004 and FY 2005.

The combined effects of the increased utilization rates and increased costs-per-claim for the ABD population, as well as other eligibility groups, are expected to result in an increase in prescription drug spending of approximately 23 percent in FY 2003, 14 percent in FY 2004, and 13 percent in FY 2005. Estimated expenditures for prescription drug services are \$1.76 billion in FY 2004 and \$1.99 billion in FY 2005.

Offsetting the prescription drug services expenditures is the prescription drug rebate estimated at \$372 million in FY 2004 and \$430 million in FY 2005.

**Medicaid Expenditures.** For the upcoming biennium, LSC's baseline forecast for Medicaid expenditures is approximately \$9.02 billion in FY 2004 and \$9.69 billion in FY 2005. Our estimated expenditures are 1.04 percent below the Office of Budget and Management's (OBM's) baseline forecast for FY 2004 and 2.78 percent below their forecast for FY 2005. LSC's forecast is lower than the executive's forecast by the following amounts:

	<b>State</b>	<b>Federal</b>	<b>Total</b>
<b>FY 2004</b>	\$ 39.0 million	\$ 55.3 million	\$ 94.3 million
<b>FY 2005</b>	\$ 111.6 million	\$ 158.0 million	\$ 269.6 million

In FY 2004, the difference between LSC's forecast and OBM's forecast is \$94.3 million, of which \$39.0 million is state share. In FY 2005, the difference between the two forecasts is \$269.6 million, of which \$111.6 million is state share.

We have not yet met with OBM and JFS to discuss the cost management initiatives that are assumed in the Governor's Blue Book. Therefore, this is a baseline forecast assuming no policy changes. We will meet with OBM and JFS to discuss the Governor's recommended cost management initiatives and will provide an updated comparison of our expenditure estimates in the LSC Red Book.

In closing Mr. Chairman, I have simply highlighted the forecast. Included in the packet is much more detail and analysis on all the topics I have covered.

I would be happy to answer any questions the committee may have.