ISSUE BRIEF

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Medicaid Coverage for Adults in New York, 2001-2003: Trends and Policy Implications

JUNE 2006

The Medicaid Institute at United Hospital Fund provides information and analysis explaining New York's Medicaid program, with the goal of helping all stakeholders redesign, restructure, and rebuild the program.

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Medicaid coverage among non-elderly, non-disabled adults[1] in New York State nearly doubled between 2001 and 2003.[2] The magnitude of the increase in adult enrollment, which was fueled by a combination of policy changes and economic conditions, and its impact on Medicaid costs have important implications for New York's current debate about Medicaid coverage and spending. While Medicaid spending in New York increased significantly between 2001 and 2003, the vast majority of that growth was unrelated to the unprecedented increase in adult enrollment. Increased spending on adults accounted for less than a quarter of Medicaid's total spending increase—even though adult enrollees represented nearly two-thirds of the overall increase in enrollment.

[1] Throughout this paper "adults" refers to non-disabled, non-elderly individuals aged 19-64 who are enrolled in or eligible for Medicaid.
[2] All findings are reported on the basis of federal fiscal years.

Policy changes and economic conditions lead to enrollment growth

Policies affecting Medicaid enrollment among adults between 2001 and 2003 included expansions of eligibility as well as both temporary and long-term reforms that simplified new Medicaid applications and renewals of coverage. Implementation of the State's Family Health Plus (FHP) expansion, enacted in 1999, increased Medicaid's income limits to 100 percent of the federal poverty level (FPL) for childless adults and 150 percent of FPL for parents of children under 21 who live at home, making several hundred thousand adults newly eligible for public coverage. In addition, implementation of a June 2001 New York State Court of Appeals decision—*Aliessa v. Novello*[3]—extended Medicaid eligibility to adult legal immigrants otherwise eligible for the program.

Policy changes and economic forces interacted to create an unprecedented increase in Medicaid enrollment among adults.

Changes to the Medicaid application and renewal process also played an important role in Medicaid's enrollment growth among adults. Disaster Relief Medicaid (DRM)—implemented in New York City after the September 11 World Trade Center attacks disabled key government information systems—suspended many requirements for establishing Medicaid eligibility. Between September 2001 and January 2002, some 280,000 adults[4] filed one-page applications containing neither an asset test nor documentation requirements and gained near-immediate Medicaid coverage.[5]

Similarly, automatic renewal of Medicaid coverage for New York City enrollees suspended—through December 2002—the obligation to document ongoing eligibility, preventing many enrollees from losing coverage during the annual renewal process.

Long-term policy changes, implemented after DRM's termination, also contributed to ongoing increases in adult Medicaid enrollment. These reforms simplified both the application and renewal processes by allowing applicants to attest to, rather than document, their social security numbers and family asset levels. Elimination of the required face-to-face interview, introduction of preprinted mail-in forms, and, for New York City residents, a reduction of the requirement to document income further simplified

[3] *Aliessa v. Novello*, 96 N.Y. 2d 418 (2001).
[4] Children accounted for the balance of DRM's 342,000 enrollees.
[5] Cooper R et al. 2002. *Disaster Relief Medicaid: Lessons Learned.* New York: Children's Defense Fund of New York.

renewals. In addition, expansion of facilitated enrollment, previously allowed only for children, permitted health plans and community-based organizations to help adult applicants navigate the enrollment process.

The impact of these policy reforms—which made more adults eligible for Medicaid while making it easier for them to gain and retain coverage—would, in all likelihood, have been substantial regardless of prevailing economic conditions. But during enactment of these reforms, New York experienced a recession, making even more adults eligible for Medicaid because of job losses and declines in family income. Thus, policy changes and economic forces interacted to create an unprecedented increase in Medicaid enrollment among adults.

Figure 1

Medicaid enrollment (in thousands) and growth rates
New York State: 2001-2003

	2001	2003	Growth
Adults	590	1,128	91%
Children	1,309	1,570	20%
Disabled	607	621	2%
Elderly	324	337	4%
Total	2,830	3,655	29%

Note: Categories may not sum to total due to rounding.

Following a gradual decline in enrollment between 1994 and 2001—a period that included a long economic expansion and New York's implementation of the federal welfare reform law—average monthly Medicaid enrollment among adults rose from about 600,000 in 2001 to more than 1.1 million in 2003—an increase of 91 percent. Increases in Medicaid enrollment for children, the disabled, and the elderly were far lower (Figure 1).

Medicaid spending per adult enrollee declines

During the same period when Medicaid coverage for adults nearly doubled, spending per adult enrollee declined from$4,086 in 2001 to $3,754 in 2003. Unadjusted for health care inflation, adult Medicaid enrollees were, on average, 8 percent less costly in 2003 than in 2001. Per capita Medicaid

Figure 2

Medicaid spending and growth per capita
New York State: 2001-2003

	2001	2003	Unadjusted Growth	Inflation-adjusted Growth
Adults	$ 4,086	$ 3,754	-8%	-15%
Children	1,872	2,071	11%	3%
Disabled	21,437	26,172	22%	13%
Elderly	21,914	25,319	16%	7%

spending for children, the disabled, and elderly enrollees, by contrast, experienced double-digit increases over the same period. Taking into account increases in the price of medical services of about 8 percent between 2001 and 2003, real per capita Medicaid spending for adults decreased 15 percent.[6] By contrast, inflation-adjusted per capita spending increased for all other Medicaid enrollment groups (Figure 2).[7]

When Medicaid enrollment increases rapidly, it is possible for a large share of new enrollees to distort estimates of per capita spending. A per capita decline in Medicaid spending can be caused artificially by a decline in the duration of coverage provided to each enrollee, if, for example, many new

Figure 3

Average duration of coverage among adults
New York State: 2001-2003

	2001	2003
Average monthly enrollment (in thousands)	590	1,128
Enrolled at any point (in thousands)	825	1,454
Average months covered	8.6	9.3

enrollees gained coverage late in the year. However, between 2001 and 2005, the average duration of coverage actually increased from 8.6 months (out of a possible 12) to 9.3 months. Not only did more adults gain

[6] The Consumer Price Index for Medical Care, produced by the U.S. Department of Labor's Bureau of Labor Statistics, estimates a 7.7 percent increase in the price of medical care in the New York region during this time period.

[7] Because different enrollee groups have differing patterns of health care service usage—elderly enrollees, for example, use more long-term care services than do children—a single measure of medical inflation is an imperfect index for assigning and comparing changes in service use.

Medicaid coverage between 2001 and 2003, but they also were covered for longer periods (Figure 3).

Explaining declines in per capita spending

Declines in per capita Medicaid spending can be driven by declines in the price of services and declines in the volume or intensity of service use. Since neither the market prices of health care services nor the Medicaid reimbursement rates set by New York's policymakers decreased between 2001 and 2003, the decline in per capita Medicaid spending on adults appears to be driven by a reduction in service use. One potential explanation for this lower rate of utilization is a lower incidence of illness among new enrollees. In other words, new adult enrollees—whether newly eligible due to increased income limits under FHP, job losses that lowered family income into the eligibility range, or the State's new eligibility rules for immigrants—may have been less costly simply because they were in better health.

The decline in per capita Medicaid spending on adults appears to be driven by a reduction in service use.

Because higher-income individuals are, on average, healthier than lower-income individuals,[8] and because these distinctions are magnified at the lower end of the income distribution,[9] higher-income adults newly eligible for FHP under its increased income limits likely had lower rates of illness than existing Medicaid enrollees. Similarly, adults gaining eligibility during the period's economic downturn, by virtue of losing jobs with incomes that had previously disqualified them, were also likely to have a lower incidence of illness than those already eligible. Finally, adult immigrants have been shown to account for far lower per capita health expenditures under public coverage than U.S.-born adults.[10]

In addition, newly enrolled adults who had previously been eligible for Medicaid may also have had lower rates of illness than those already enrolled. A longstanding pattern within New York's Medicaid program is that relatively healthy eligible adults often fail to complete the enrollment process, while eligible adults who are sick enough to require hospitalization are virtually guaranteed enrollment through the efforts of

[8] Deaton A. 2002. Policy implications of the gradient of health and wealth. *Health Affairs* 21(2):13-30.
[9] Mechanic D. 2002. Disadvantage, inequality, and social policy. *Health Affairs* 21(2):48-59.
[10] Mohanty S et al. 2005. Health care expenditures of immigrants in the United States: A nationally representative analysis. *American Journal of Public Health* 95(8):1431-38.

the hospital.[11] This pattern ensures that Medicaid typically enrolls the sickest and most costly of its eligible adults, while leaving uninsured many who are potentially less costly. New York is not unique in this regard; nationally, Medicaid attracts and retains a disproportionately unhealthy and costly subset of the eligible population.[12] Policy reforms that simplified the New York Medicaid application process between 2001 and 2003 attracted previously eligible adults who may not have enrolled earlier because they did not face urgent health care needs.

Policy implications

It may be impossible to disentangle the effects of the many policy changes contributing to increased enrollment, or even to separate, with any precision, the aggregate impact of policy changes from the impact of economic conditions. Nevertheless, New York's Medicaid expansion for adults has clear implications for policy. Ultimately—by way of challenging economic conditions, expanded eligibility, and simplified applications and renewals—New York's Medicaid program covered nearly 1.1 million adults in 2003, just two years after covering fewer than 600,000. At the same time, adults' average duration of coverage increased and per capita Medicaid spending on adults declined.

Overall, Medicaid enrollment in New York State grew by 825,000 people between 2001 and 2003. The increase in adult enrollment of 537,000 represented 65 percent of the total increase; children, the disabled, and the elderly accounted for the remaining increase of 288,000. Because the vast

Figure 4

Medicaid spending (billions) New York State: 2001-2003

	2001	2003	Increase
Adults	$ 3.4	$ 5.5	$ 2.1
Children	3.1	4.2	1.1
Disabled	14.7	18.3	3.6
Elderly	8.4	10.2	1.8
All enrollees	$ 29.6	38.2	8.6

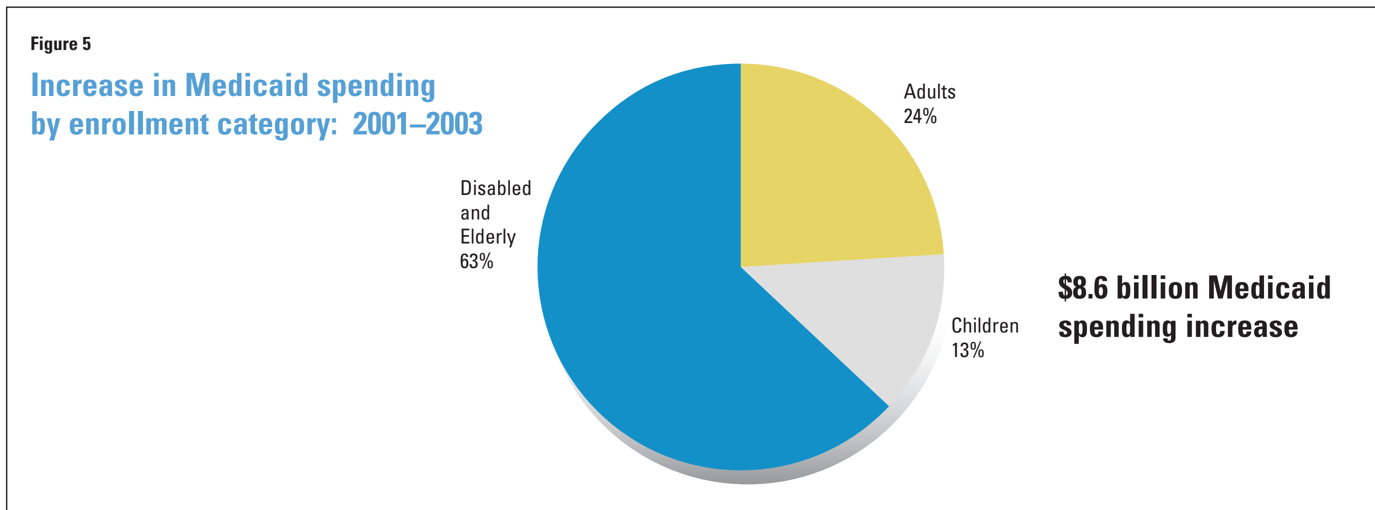
Note: Categories may not sum to total due to rounding.

[11] Birnbaum M et al. 2004. *Estimating the cost of enrolling New York City's eligible but uninsured adults in Medicaid.* New York: United Hospital Fund.

[12] Holahan J. 2001. Health status and the cost of expanding insurance coverage. *Health Affairs* 20(6):279-86. Davidoff A et al. 2001. *Medicaid-eligible adults who are not enrolled: Who are they and do they get the care they need?* Washington, DC: Urban Institute.

majority of adult New Yorkers in Medicaid's income range do not have private health insurance coverage,[13] it is likely that—but for Medicaid—most would otherwise have been uninsured.

Medicaid spending on services provided directly to enrollees increased by $8.6 billion between 2001 and 2003 (Figure 4).[14] During this period, New York's state and local budgets faced considerable financial stress, and the



increase in Medicaid spending generated significant concern. The large and visible increase in adult enrollment became a central focus of policymakers and opinion leaders, and was often highlighted as a potential driving force behind Medicaid spending growth.

The data tell a different story. The increase in spending on adults—$2.1 billion—accounted for 24 percent of the total increase in Medicaid spending between 2001 and 2003 (Figure 5). To put this in perspective, the increase in spending on disabled and elderly enrollees was $5.4 billion—63 percent of the total increase—despite the fact that the disabled and elderly accounted for just 3 percent of Medicaid enrollment growth during this period. The vast majority of New York's Medicaid spending growth between 2001 and 2003, therefore, was unrelated to the State's unprecedented increases in adult Medicaid enrollment.

[13] Hubert E et al. 2005. *Health insurance coverage in New York, 2002-2003*. New York: United Hospital Fund.
[14] Medicaid spending on services provided directly to enrollees does not include payments to "disproportionate share hospitals."

Appendix: Data and Methods

The timing of Disaster Relief Medicaid (DRM), automatic renewal, and implementation of Family Health Plus (FHP) and *Aliessa v. Novello* allows for a comparison of post-policy Medicaid enrollment and spending against baseline enrollment and spending during FFY 2001, before those policies went into effect.

DRM's streamlined application was implemented in New York City on September 24, 2001, the same day that the FHP and *Aliessa v. Novello* expansions were implemented there. These policies were in effect for only seven days in FFY 2001, which ended on September 30. The New York City Human Resources Administration, which administers Medicaid, estimated that 97 percent of DRM enrollment took place in FFY 2002, before DRM ended in January 2002.[15]

Automatic renewal of Medicaid coverage in New York City and the FHP expansion upstate were both implemented in October 2001, the first month of FFY 2002. The *Aliessa v. Novello* expansion upstate was implemented during FFY 2002. Automatic renewal in New York City ended after the first quarter of FFY 2003.

This analysis uses New York State Department of Health enrollment reports as the basis for measuring average monthly enrollment within each federal fiscal year. To estimate per capita Medicaid spending, we matched Medicaid Statistical Information System (MSIS) data on paid claims, produced by the Centers for Medicare and Medicaid Services (CMS), with CMS MSIS data on the number of adults who were enrolled in Medicaid—including Family Health Plus—at any point during the year. These estimates were then adjusted to reflect actual Medicaid payments reported on the CMS 64 Form. The regional Consumer Price Index for medical care, produced by the U.S. Department of Labor's Bureau of Labor Statistics, was used to adjust for the increase in the cost of health care services between 2001 and 2003.

The Medicaid Institute at United Hospital Fund is pleased to acknowledge Linda Bilheimer, Sherry Glied, Kathryn Haslanger, and John Holahan for their guidance and comments on earlier drafts of this analysis.

[15] New York City Human Resources Administration. March 18, 2002. *Estimated number of DRM cases by HRA field office, location, and month.*