

**medicaid**  
and the **uninsured**

April 2002

**The Financing Of Illinois’  
Prescription Drug Demonstration Project**

**Overview**

On January 28, 2002, the Department of Health and Human Services granted Illinois a waiver that allows the state to extend comprehensive prescription drug coverage to seniors with income up to 200 percent of the poverty line using federal Medicaid matching funds. The new coverage replaces a significant portion of a state-funded pharmacy program that helped some 50,000 seniors pay for prescription drugs needed to treat selected conditions in fiscal year 2001.<sup>1</sup> To date, nearly all of the discussion about Illinois’ “waiver” or “demonstration project” has focused on the expansion of prescription drug coverage for low-income seniors. Although it has been less widely recognized, the demonstration project also includes fundamental changes to the state’s financing of its Medicaid program for the elderly.

One of the defining features of the Medicaid program is that it provides states with an entitlement to federal Medicaid matching funds. To pay for its new prescription drug program, however, Illinois has foregone the federal government’s guarantee that it will match as needed the amount the state spends on its elderly Medicaid population. Instead, the demonstration project establishes an upper limit or “cap” on the amount the federal government will match of Illinois’ spending on its elderly Medicaid population over the next five years. The cap is based on the amount the state anticipated it would need to cover its elderly Medicaid population in the absence of its new demonstration project. The state, however, must pay for the cost of its elderly Medicaid population and its new prescription drug program out of the capped amount of federal funding. The state’s theory is that its demonstration project will prevent a significant number of seniors from becoming sick and/or poor enough to qualify for full Medicaid coverage, and that the savings it generates by “diverting” seniors from Medicaid eligibility will be sufficient to pay for its new prescription drug program. If, however, the state’s spending on these two programs exceeds the capped amount, it will need to pay for the extra costs on its own without the benefit of federal matching funds, creating a potentially strong incentive for the state to avoid reaching the cap.

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<sup>1</sup>The portion of the state-funded program that remains in place covers people with disabilities, as well as seniors with income between 200 percent and 250 percent of poverty.

It is not possible to know whether Illinois will be able to finance both its new prescription drug program and the cost of serving elderly Medicaid beneficiaries within the capped amount of funding available to it. If it appears that the state's need for federal funds might outstrip what is available under the cap for any reason, it will face competing pressure to cut back prescription drug coverage for low-income seniors and/or to cut back comprehensive services for low-income, elderly beneficiaries. This could occur if costs are higher than expected for the new prescription drug program or if the cost of serving elderly beneficiaries under Medicaid is higher than anticipated.

Even if Illinois' experiment succeeds, it is notable that Illinois' demonstration project sets a precedent by replacing open-ended federal matching funds for a state's elderly Medicaid population with an overall cap on federal funding in order to generate resources that can be spent on prescription drugs for a different group of seniors.

### **Key Questions and Answers about the Financing Mechanism Behind Illinois' New Prescription Drug Demonstration Project**

Under policies established by the Department of Health and Human Services in conjunction with the Office of Management and Budget, the federal government has long required that Medicaid demonstrations be "budget neutral." Under the budget neutrality requirement, a state must assure the federal government that it will use no more federal Medicaid funds on its demonstration project than it would have used if the project had never been implemented. To meet the budget neutrality requirement for its demonstration project, Illinois agreed that it would spend no more federal Medicaid funds on its new drug program and its elderly Medicaid population than it anticipates it otherwise would have spent on its elderly Medicaid population in the absence of the demonstration project.

*How much does Illinois currently spend on its elderly Medicaid population?*

At present, Illinois serves some 154,000 elderly beneficiaries on Medicaid at an average cost of \$13,759 a year. In fiscal year 2002, the state expects to spend a total of \$2.1 billion on these elderly beneficiaries. Of this amount, the federal government will match 50 percent (Illinois' regular Medicaid matching rate). The elderly who currently qualify for Medicaid in Illinois include individuals who have income below 85 percent of the poverty line, as well as those who "spend down" to coverage under the state's medically needy eligibility category due to high medical bills. (During the upcoming fiscal year, the state will expand its coverage of elderly people with income below 85 percent of poverty line to 100 percent of poverty.)

*How much would Illinois spend on its elderly Medicaid population over the next five years if it did not implement its prescription drug program?*

The state anticipates that it will spend a total of \$14.6 billion on its elderly Medicaid population over the next five years (fiscal year 2003 – fiscal year 2007) if its new prescription drug program is not implemented. (Of this amount, the federal government

is expected to match 50 percent.) To arrive at the \$14.6 billion figure, the state assumed that the number of elderly people on its Medicaid program would increase 5 percent a year, while the per capita cost of serving them would increase by 5.5 percent a year. Taken together, these assumptions result in an average annual rate of increase in spending on the state's elderly Medicaid population of 10.8 percent a year. (In comparison, the Congressional Budget Office assumes that national spending on elderly Medicaid beneficiaries will increase at an average annual rate of 8.7 percent between fiscal years 2003 and 2007.)

To comply with budget neutrality rules, Illinois must establish that over the next five years it will spend no more under the demonstration on its prescription drug program and its elderly Medicaid population than it otherwise would have spent on its elderly Medicaid population alone. Thus, under the terms of its budget neutrality agreement, the \$14.6 billion figure also determines the total amount of federal matching funds that will be available to the state over the next five years for its elderly Medicaid beneficiaries and its prescription drug program.

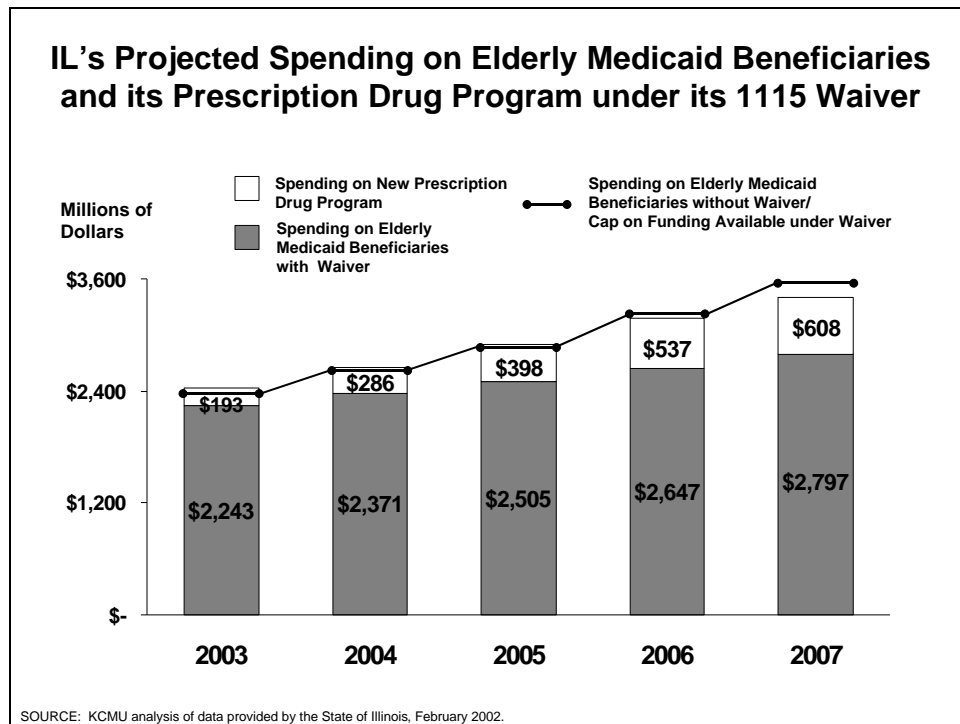
*How does Illinois plan to live with the capped amount of funding available for its new prescription drug program and its elderly Medicaid population?*

Illinois anticipates that it will be able to finance the cost of providing care to its elderly beneficiaries under Medicaid and operate its new prescription drug program for \$14.6 billion over the next five years. Although it might seem implausible that a state could operate two programs for the price of one, Illinois' theory is that providing prescription drug coverage to a broad array of low-income seniors will prevent a significant number of seniors from becoming sick and/or poor enough to qualify for full Medicaid coverage. Illinois expects that the savings it generates by "deterring" a significant number of seniors from becoming eligible for and enrolling in Medicaid will be sufficient to pay for the cost of its new prescription drug program.

Specifically, Illinois assumes that its new prescription drug program will deter 7,500 elderly people from becoming sick and/or poor enough to qualify for Medicaid in the first year of its demonstration (fiscal year 2003). These 7,500 people represent 5 percent of the 162,000 elderly individuals whom the state anticipates would have enrolled in Medicaid if it had not secured its demonstration. By the fifth year of its demonstration project (fiscal year 2007), the state assumes that 41,400 elderly people will be deterred from becoming eligible for and enrolling in Medicaid by the prescription drug program. These 41,400 people represent 21 percent of the 197,000 individuals who would have enrolled in Medicaid in the absence of the new prescription drug program. By deterring these individuals from eligibility for full Medicaid, the state anticipates it will be able to reduce the annual rate of growth on Medicaid spending for the elderly from 10.8 percent to 5.7 percent over the next five years.

Since the cap agreed to in the demonstration project assumes spending growth of \$10.8 billion, if the state is successful in reducing spending on its regular Medicaid program for the elderly, the state will generate "room" under its cap to finance the prescription drug

program. The new program is expected to cost a total of \$2 billion over the next five years. Although the cost of the prescription drug program starts at a relatively modest \$193 million in fiscal year 2003, it is expected to rise to \$608 million in fiscal year 2007. The rapid rise reflects the assumption that the number of people served under the program will increase from 194,000 in fiscal year 2003 to 372,000 in fiscal year 2007, while the cost of providing prescription drugs to these individuals will grow at an average annual rate of 13 percent a year from \$996 per person a year in fiscal year 2003 to \$1,635 per person a year in fiscal year 2004.



As Figure 1 illustrates, the state expects its demonstration project will be budget neutral over the five-year life of the project as required by CMS, but not in the early years during which the project is in place. In the first, second, and third year of the demonstration project, the state expects it will spend more on its new prescription drug program and its elderly Medicaid population than allowed under the cap. However, by the fourth and fifth years of operating the waiver, the state expects it will spend less than allowed under the cap. In total over the five years, the state anticipates its spending under the demonstration project will equal \$14.6 billion, the exact amount it is allowed to spend under its cap.

*Is Illinois likely to run out of funding under its cap?*

It is difficult to evaluate whether Illinois is likely to have sufficient room under its cap to finance both the new prescription drug program and its elderly Medicaid program. If the state's new prescription drug program and elderly Medicaid population cost less than anticipated over the next five years, the state's decision to accept a federal Medicaid funding cap will not have significant consequences for the state. In effect, the cap will be

irrelevant and the state will have the opportunity to continue to make spending decisions based on the premise that the federal government will match spending as needed on Illinois' elderly Medicaid population and new prescription drug program.

For any number of reasons, however, Illinois could find that the cost of operating its new drug program or of serving elderly Medicaid beneficiaries causes its need for federal funds to exceed the amount it had anticipated it would need. The number of elderly individuals eligible for Medicaid in Illinois or cost of serving elderly Medicaid beneficiaries could rise more rapidly than expected. For example, the state might find that it needs to spend more on elderly beneficiaries in nursing homes to address widespread staffing shortfalls. Similarly, the number of elderly people who enroll in Illinois' new prescription drug program or the cost of providing prescription drugs to these beneficiaries could be higher than anticipated.

*What happens if Illinois runs out of funding under its cap?*

If it appears that Illinois' need for federal funds might exceed the amount available under the cap, the implications for elderly Medicaid beneficiaries could be significant. The state would likely need to choose between cutting spending on elderly Medicaid beneficiaries, cutting spending on its prescription drug program, or reaching the federal funding cap and paying for any unanticipated program costs entirely with state funds.<sup>2</sup> Given that the prescription drug program provides a low-income population with a popular benefit and is expected eventually to serve nearly twice as many elderly people as Medicaid, it appears likely that the state may face particular pressure to reduce spending on elderly Medicaid beneficiaries. The state could do so by rolling back eligibility for optional elderly Medicaid beneficiaries, making it more difficult for eligible individuals to apply for and retain coverage, cutting provider reimbursement rates, eliminating selected benefits, increasing the cost sharing obligations that these beneficiaries face, or taking other steps, such as increasing the efficiency with which it provides prescription drugs to elderly Medicaid beneficiaries, that would reduce Medicaid expenditures.

If it appears that Illinois is running into difficulties, the federal government also might decide not to enforce the budget neutrality requirements of the state's demonstration project. It, however, may be risky for Illinois to rely on this possible outcome. As a result, the budget neutrality requirements of the demonstration project could significantly affect the state's decisions about how to operate its Medicaid program for the elderly and new prescription drug program even if they ultimately are not enforced.

*How is the strategy for establishing budget neutrality in Illinois different from that commonly employed under other 1115 demonstration projects?*

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<sup>2</sup>The state also technically has the option to cancel implementation of its demonstration project. If it cancels the demonstration project, however, Illinois is liable to the federal government for any spending incurred to date in excess of its cap. Since the state anticipates its demonstration project costs money in the early years and saves money only in the later years, the state is likely to find canceling the demonstration project before the end of the five-year period to be an unattractive option.

In the past, states that have used 1115 demonstration projects to expand coverage have complied with the budget neutrality requirement in a variety of ways. The common strategies include the following:

- **Reducing DSH payments.** Some states have reduced their disproportionate share hospital payments to generate savings that were used to finance the cost of a new coverage expansion.
- **Adopting a per capita cap.** Other states have adopted a “per capita cap” approach to complying with the budget neutrality requirement. Under this strategy, a state agrees to accept a set amount of funding (or “per capita limit”) for each person the state could have enrolled in Medicaid without its 1115 waiver. To the extent the state can deliver services to these individuals for less than the per capita limit, it can use the “savings” to help finance the cost of covering people made eligible for coverage by the state’s 1115 waiver. (For example, a state might be able to reduce the per capita cost of serving individuals by adopting a new Medicaid managed care initiative.) Under a per capita cap, a state is “protected” from running out of federal Medicaid matching funds if the number of people who enroll in Medicaid turns out to be higher than expected. It, however, is not protected from running out of federal matching funds if the per capita cost of serving individuals turns out to be higher than anticipated.
- **Using unspent SCHIP funds.** Beginning in August of 2000 under the Clinton Administration, states were given the option to use unspent SCHIP funds to finance the cost of expanding coverage for parents under 1115 waivers if certain conditions were met. More recently, the Bush Administration has expanded this option and states now can use unspent SCHIP funds to help establish budget neutrality for expansions of coverage to childless adults, as well as parents.

The Illinois strategy for establishing budget neutrality appears to be different from the strategies commonly employed by other states in some significant respects.<sup>3</sup>

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<sup>3</sup> HHS has approved a few demonstration projects with financing mechanisms that bear a greater resemblance to Illinois’s than the commonly used means of financing demonstration projects outlined above. Most notably, the state of Tennessee operates a Medicaid 1115 waiver demonstration project that includes an overall cap on the availability of federal Medicaid matching funds. The cap applies to all of the state’s Medicaid beneficiaries, including elderly beneficiaries. In the case of Tennessee, however, the state included policy changes in its demonstration project that affect elderly Medicaid beneficiaries. By comparison, Illinois included elderly Medicaid beneficiaries in its demonstration project exclusively to establish budget neutrality and generate resources for its new prescription drug program.

Similarly, HHS has approved demonstration projects in Maine and the District of Columbia that allow them to extend Medicaid eligibility to HIV+ individuals who have not yet developed AIDS. To establish budget neutrality for these projects, Maine and the District of Columbia agreed to an overall cap on federal Medicaid matching payments that applies to people who qualify for coverage under “regular” Medicaid rules because they have AIDS and those who qualify under the expansions because they are HIV+ individuals. In contrast to Illinois’s funding cap on elderly Medicaid beneficiaries, the funding cap included in the HIV projects target a well-defined, narrow population of Medicaid beneficiaries. Moreover, the overlap between the expansion population and the regular Medicaid beneficiaries subject to the cap in these demonstrations is far stronger and direct -- all individuals with AIDS were previously HIV+ individuals who had not yet developed AIDS and, thus, might at one time have been helped by a policy that extends Medicaid coverage to HIV+ individuals.

First, the Illinois waiver imposes a fixed, overall cap on the federal Medicaid funds available to finance the state's demonstration program and elderly Medicaid population. Unlike under a per capita cap, the federal government will not adjust the amount of federal matching funds available to Illinois even if the number of elderly Illinois residents who qualify for Medicaid turns out to be higher than expected. Illinois, thus, is at risk of running out of federal Medicaid matching funds if either the per capita cost of serving elderly beneficiaries is higher than anticipated or if the number of elderly beneficiaries who enroll in coverage exceeds expectations.

- Second, the budget neutrality calculations behind Medicaid 1115 demonstration projects often have not affected the financing of care provided to elderly people, a particularly vulnerable and expensive group of Medicaid beneficiaries.
- Third, to the extent that overall caps on funding for elderly Medicaid beneficiaries have been included in the financing of demonstration projects in the past, it has been because they also were affected by policy changes made under the demonstration project. In the case of Illinois, the overall cap on federal Medicaid matching funds for the elderly population was included as a means of generating resources that can be used to help finance the state's new prescription drug program even though the state's elderly Medicaid beneficiaries are not otherwise affected by policy changes made under the demonstration project.

## Conclusion

The mechanism for financing Illinois' new prescription drug demonstration project represents a significant departure from the way that Medicaid operates by eliminating open-ended federal Medicaid funds for the state's elderly Medicaid population as a means of generating resources to help more moderate-income seniors. The state's waiver is the first in the nation to set an overall cap on the amount of federal matching funds that will be available to pay for elderly beneficiaries -- one of the most expensive and vulnerable groups served under Medicaid -- as a means of generating resources that can be used to establish a prescription drug program for more moderate income seniors. If the state's expectations that it can deter elderly people's need for Medicaid services by providing prescription drug coverage to a large population of seniors are borne out, the cap may not have significant implications in Illinois. If, however, the cost of serving elderly Medicaid beneficiaries or the cost of the new prescription drug program turns out to be higher than expected, Illinois will face competing pressure to maintain prescription drug coverage for moderate income seniors versus maintain comprehensive services for poor, elderly beneficiaries.

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