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Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006

Results from a 50-State Survey

EXECUTIVE SUMMARY

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Executive Summary

As states deliberated FY 2006 budget decisions, most states were emerging from an extended period of extreme fiscal stress in their budgets. State revenues were starting to rebound and overall state spending growth was returning to historic averages. However, despite positive indicators, the economic recovery has been uneven across the country and 26 states are expected to face budget shortfalls in FY 2006. Additionally, Hurricanes Katrina and Rita have placed new stress on the economies of the Gulf States and the national economic impact of the hurricanes is still unknown.

During the most recent economic downturn, Medicaid costs and enrollment grew when more people fell into poverty and became eligible for the program. Medicaid serves as a critical safety-net program for providing health coverage and long-term care assistance to over 39 million people in low-income families and 13 million elderly and disabled people. It is also a pivotal piece of the overall health care delivery system filling in gaps in Medicare coverage and supporting safety-net providers. As the economy begins to recover, Medicaid spending and enrollment growth are starting to slow. However, health care costs and enrollment growth tied to demographics, poverty rates and changes in employer-sponsored health coverage, factors beyond the control of Medicaid, continue to drive program spending growth. Again, in FY 2005 and FY 2006, in response to competing demands and fiscal pressures, states implemented and plan to implement another round of Medicaid cost containment policies to try to stem cost growth.

As states grapple with Medicaid spending growth for another year, the nature of the state and federal partnership for Medicaid continues to evolve. This fall, the federal government will consider a variety of Medicaid savings proposals to meet the FY 2006 federal budget requirements to cut up to $10 billion from the program over the next five years. There is some discussion about imposing further reductions on Medicaid and other entitlement spending to offset expenditures related to rebuilding efforts in the states devastated by the recent hurricanes. Some of these proposed Medicaid reductions could shift costs to the states at a time when many states already face additional fiscal responsibility for the program as a result of formula-driven reductions in the federal match rates and the implementation of the new Medicare Part D program.

For the fifth consecutive year, the Kaiser Commission on Medicaid and the Uninsured has worked with Health Management Associates to survey state Medicaid officials about changes in Medicaid spending, enrollment trends and policy directions as states finished one fiscal year (FY) and were entering the next. This report focuses on FY 2005 and FY 2006. Drawing from data provided in previous surveys, this report also looks at these changes in the context of Medicaid actions taken since 2002. The key findings from this latest survey include the following:

As the economy began to recover, state revenue growth started to climb and Medicaid spending growth slowed. From 2000 to 2002, state revenues plummeted, more individuals lost jobs, fell into poverty and became eligible for Medicaid as a result of the economic downturn. Rapid growth in enrollment, followed by rising health care costs,

were the dominant factors contributing to Medicaid spending growth during this period. State revenues are now beginning to rebound and Medicaid spending growth rates slowed for the third straight year to an estimated 7.5 percent in FY 2005 after peaking in 2002 at 12.7 percent (Figure 1). For FY 2005 and FY 2006, states reported that health care costs were the most significant factor driving Medicaid spending although enrollment growth, especially for the more costly elderly and disabled populations, remains a significant factor driving Medicaid spending growth. While Medicaid growth still outpaces state revenue growth, Medicaid spending continues to grow at a slower pace than private health insurance premiums.

In FY 2005, the state share of Medicaid costs grew faster than total costs, and states are projecting the same for FY 2006 as a result of the expiration of temporary federal fiscal relief that enhanced federal Medicaid matching rates (FMAP) by 2.95 percentage points through the end of FY 2004 and formula driven reductions in the federal match rates. For FY 2006, 29 states will experience match rate reductions. In addition, the diminishing availability of special financing arrangements is forcing several states to use additional state general fund dollars to replace reductions in federal matching dollars that had helped to fund their programs.

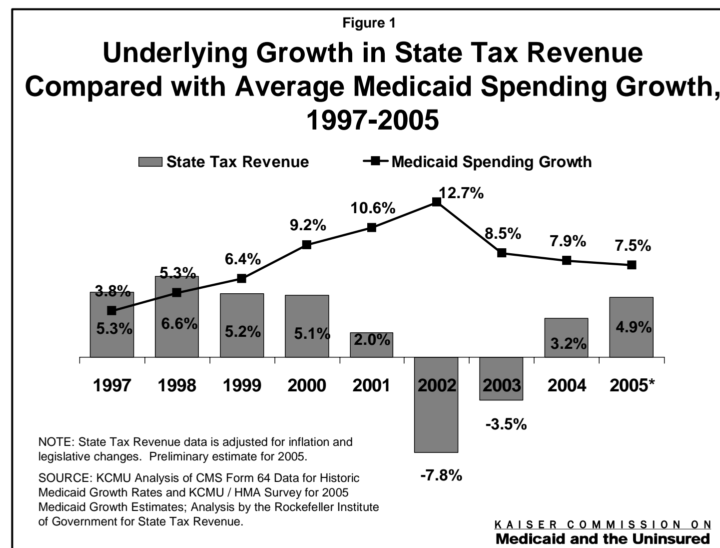
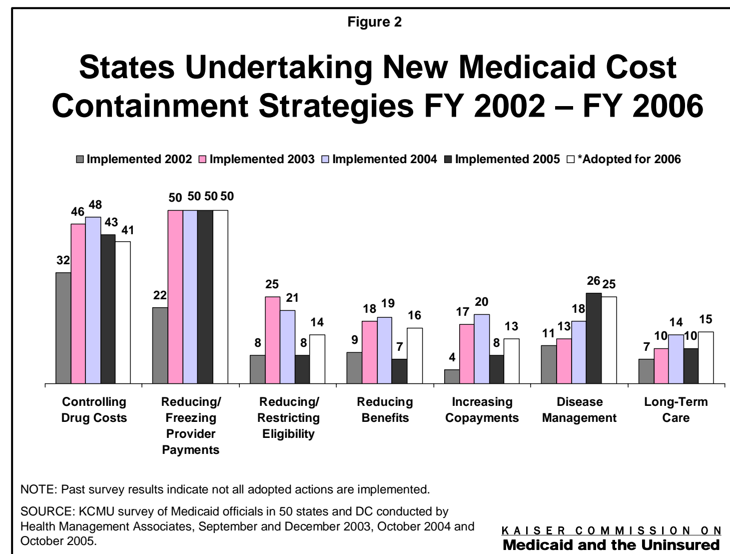


Figure 1
Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2005

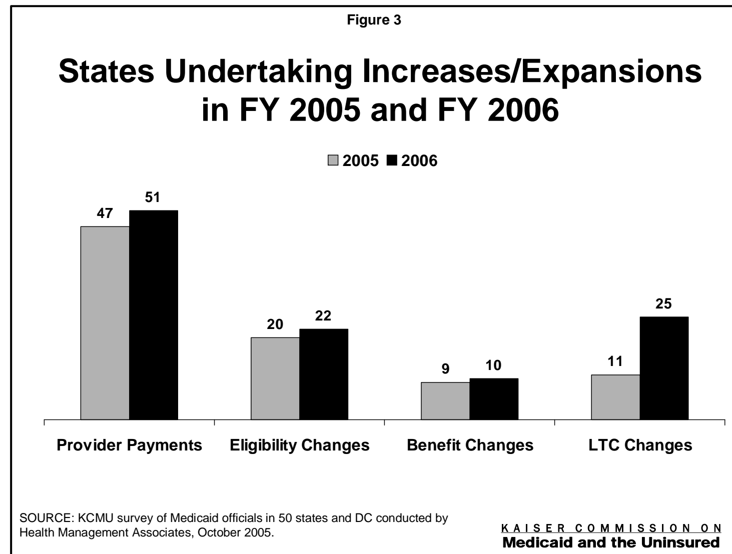
NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2005.
SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2005 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

The rate of Medicaid enrollment growth dropped from a high of 9.9 percent in 2002 to 4 percent in FY 2005 and a projected 3.1 percent in FY 2006, which would be the fourth straight year of slowing growth rates. Decline in enrollment growth rates can be attributed to the economic recovery as well as some state policy initiatives to restrict Medicaid eligibility. However, enrollment levels continue to grow as the number of people in poverty rises, employer sponsored coverage declines and some states restore eligibility cuts, expand programs and introduce eligibility simplifications to help offer coverage to many individuals who otherwise would be uninsured. Medicaid officials reported that they worry that demographic trends will result in the enrollment of more elderly and people with disabilities who are more costly to the Medicaid program.

All states continued to implement and adopt a wide array of Medicaid cost containment strategies in FY 2005 and FY 2006. As in years past, state cost containment efforts were focused on controlling pharmacy costs and restricting provider payment rates (Figure 2). The number of states implementing eligibility cuts, benefit cuts and increases to copayments all declined in FY 2005, while efforts to implement disease management programs were expanded. Looking forward to FY 2006, more states adopted measures to restrict eligibility, cut benefits or increase co-payments. Particularly notable are deep eligibility cuts in Florida, Missouri and Tennessee that will eliminate coverage for a significant number of people. For FY 2006, two states (Mississippi and Florida) are reducing eligibility for aged and disabled beneficiaries which will lower the amount that those states will be required to pay the federal government under the "clawback" provisions of the Medicare prescription drug benefit. Fewer cost containment measures were implemented by states in FY 2005 than were originally planned which suggests the possibility that some of the FY 2006 measures similarly may not be implemented due to delays, external challenges or positive changes in state revenue projections.



In FY 2005 and FY 2006 states also implemented more positive policy initiatives such as expansions and provider rate increases than in previous years. Forty-seven states in FY 2005 and every state including the District of Columbia in FY 2006 implemented or has plans to implement at least one provider rate increase (Figure 3). Seventeen states in FY 2005 and 20 states in FY 2006 increased physician rates, a significant increase from FY 2004 when only nine states had reported physician rate increases. Some Medicaid officials indicated that rate increases were needed to address growing concern over access to physician care, and that in some cases they were facilitated by higher than expected state revenues. More states implemented eligibility expansions or application simplifications (20 in FY 2005 and 22 in FY 2006) as states continue to use Medicaid as a vehicle to expand health insurance coverage to low-income populations. In FY 2006, 25 states plan to implement some type of long-term care expansion, mostly related to expansions in home and community-based care in an attempt to meet the growing demand for these services as Medicaid remains the dominant provider of these services.



About half of the states are developing new Medicaid proposals that would use existing Section 1115 waiver authority. A total of 25 states indicated that they planned to implement a new Section 1115 Medicaid reform waiver or amendment to an existing waiver in FY 2006. Eleven of these waivers had been submitted to CMS for approval at the time of the survey, and fourteen states were at various stages of development. Most often, Medicaid officials indicated that the primary goals of the waiver proposals were to reduce the number of persons without health coverage (14 states) or to reduce growth in Medicaid costs (13 states). However, in many recent waivers, authority to expand coverage has not been implemented or not fully implemented so overall gains in coverage have been small.

State Medicaid officials expressed concern that the implementation of the new Medicare Prescription Drug Benefit will generate challenges for beneficiaries, new fiscal responsibilities and administrative issues. In twenty-six states Medicaid officials expected their FY 2006 clawback obligations to result in increased costs for their state. Among these 26 states, a total of 19 did not expect cost savings in future years through at least 2010, despite the scheduled partial phase-down of the clawback. For FY 2006, only nine states reported that they expected savings, and 15 states expected their states to break even. The Medicare Modernization Act spells out new administrative responsibilities for states, including administering Part D Low-Income Subsidy eligibility determinations, but only nine states indicated that their budgets for FY 2006 included funding for this activity. Aside from the clawback, when asked to identify the most significant issues related to the implementation of the Part D benefit, half of the states (25) raised concerns over administrative issues including the need for computer systems changes, coordination of benefits issues, data and data exchange issues, state staffing impacts and general concerns as to the overall administrative burden.

State Medicaid officials expressed more optimism about the outlook for the future of Medicaid than in past years, but remain concerned about the long-term fiscal sustainability of the program. When asked to identify the key issues they envision for Medicaid over the next year or two, more Medicaid officials were able to look to the future whereas in the past, they were more focused on whether they could just get through the year. While the resilience and importance of Medicaid was manifested by its ability to weather an intensely difficult period in program history, continuing cost growth, demographic trends and the erosion of private health insurance as well as new responsibilities associated with the implementation of Medicare Part D will pose significant challenges for states in the future. Major concerns also remain over the potential impact of federal initiatives to control federal Medicaid spending which could shift the balance in financing the program in the direction of states, beneficiaries and providers. Medicaid officials saw little chance of these pressures abating in the absence of broader health reform that would address the growing uninsured problem and the lack of alternatives for long-term care assistance.

Methodology

For the fifth year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. The KCMU/HMA survey on which this report is based was conducted in July and August 2005 to document the policy actions states had implemented in the previous year, state FY 2005, and new policy initiatives that they had adopted, or expected to implement, in state FY 2006, which for most states had begun on July 1, 2005. The data in this report were based on survey responses and interviews with Medicaid directors and staff for all 50 states and the District of Columbia. Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey.

For FY 2005 and 2006, average rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states using Medicaid expenditures reported in the National Association of State Budget Officers (NASBO) State Expenditure Report for 2003 (October 2004 report).

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