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State Case Study:

**Medicaid and the 2003-05 Budget Crisis—
A Look At How Washington Responded**

Prepared by

John Holahan
The Urban Institute

August 2005

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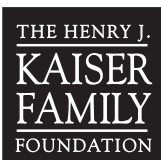
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Preface and Acknowledgments

This report is part of a Kaiser Commission on Medicaid and the Uninsured project that examined how eight states from around the nation responded to their budget crises during the 2003-05 time period, with a special focus on Medicaid and the State Children's Health Insurance Program. The state case studies review budget decisions made by state policymakers in Alabama, California, Colorado, Massachusetts, Michigan, New York, Texas, and Washington. An Overview that summarizes these eight states' experiences was published in *Health Affairs* as a web exclusive in August 2005.

This study would not have been possible without the many state officials and representatives of provider and consumer groups in the study state who gave so freely of their time and insights. We also wish to thank Erin Barringer who did a terrific job doing background research. Finally, we thank Barbara Lyons, Molly O'Malley, David Rousseau and Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured for their help throughout the project.

Medicaid and the 2003-05 Budget Crisis: A Look at How Washington Responded

Abstract

Washington filled its 2003-05 budget gaps with one-time revenue strategies and widespread spending cuts, including health programs. Washington responded to its budget problems using one-time measures, such as tobacco securitization, drawing down reserves and enacting a range of budget cuts affecting the state workforce, aid to localities and higher education. It also delayed implementing voter-approved measures to reduce class sizes and increase teacher pay at the K-12 levels. For Medicaid, numerous cuts were made including changing enrollment and eligibility policies, cutting provider payment and increasing copayments.

In the early 1990s, Washington was a leader among states in making major strides in expanding health insurance coverage. The state extended Medicaid coverage to children up to 200 percent of the federal poverty line and enacted the Basic Health Plan, a state funded program to cover low income working families up to 200 percent of the federal poverty line. In the last budget cycle the combination of the state's poor economic performance and opposition to tax increases has for the first time begun to affect health care programs.

Despite Washington's broad coverage, the state has an uninsured rate (17.3 percent) about equal to the national average; 943,000 Washington residents were uninsured in 2003. Because of its broad coverage of children the uninsured rate in 2003 for children was 8.8 percent (less than U.S. average), though this has risen since because of cutbacks described below. The uninsured rate for adults was 20.7 percent in 2003, slightly above the national average. Insurance coverage in the state deteriorated significantly between 2000 and 2003 because of both the economic decline and budget difficulties. The rate of employer-sponsored insurance fell by four percentage points – from 66.3 percent to 62.3 percent, only some of this was made up by growth in Medicaid. As a result, the uninsured rate increased by 1.9 percentage points, or by 151,300 thousand people, all among adults.¹

In recent years the state has grown increasingly conservative with a strong anti-tax movement. A ballot initiative, I-601, enacted in November 1993 constrained annual spending increases to no more than inflation plus population growth. In most years this has been less than the rate of growth in per capita income. But more recently, slower revenue growth because of the recent recession has constrained state spending. At the same time, ballot initiatives have been approved requiring that the state increase teacher salaries and reduce class sizes. Because there was no dedicated revenue source for these initiatives they reduced the availability of general revenues for other purposes. This report reviews the debate over the budget enacted for the 2003-2005 biennium and subsequent measures taken during the biennium.

Key Debates and Decisions in 2003-2005 Biennium Budget

In June 2003, the Washington state legislature enacted a \$23.1 billion biennium budget, which closed a projected gap of \$2.7 billion.² The budget gap occurred because of slower than expected revenue growth related to the recession, increases in health care costs because of rising caseloads, and ballot initiatives that required the state to increase spending on K-12 education. Other factors that contributed to the gap included rising education enrollments and prison populations.

The 2003-2005 budget followed on the heels of a budget crisis that developed in 2002 when it became clear that the 2001-2003 general fund budget of \$22.8 billion faced a shortfall of \$1.6 billion. The state enacted a supplemental 2002-2003 budget in March 2002 to close the gap.³ The supplemental budget included a tobacco securitization arrangement which meant that \$450 million in tobacco settlement payments were received immediately in lieu of \$1 billion in future payments. Washington also used \$325 million of its emergency reserve fund. Other

revenue measures, including joining a multi-state lottery and closing some tax loopholes, were adopted. There were \$654 million in budget cuts including reductions in state government, assistance to cities and counties, contributions to health benefits for state employees, public school funding, and health care programs other than Medicaid as well as elimination of a 2.6 percent cost of living adjustment for state and higher education employees.

The 2003-2005 biennium presented new problems, in part because of the decisions made in 2002 described above. That is, legislators had already made significant cuts in compensation of state employees and in aid to localities. Ballot initiatives seemingly required increased spending on K-12 education, while demographic changes *i.e.*, the baby boom, were increasing the demand for education. Many of the accounting tricks and gimmicks that had been used in the past biennium had been used up. There was little support for cutting health programs in a major way and there was strong opposition in the state to tax increases. With this background, the state faced a set of very difficult choices in considering how to solve the \$2.7 billion budget deficit.

Revenue Measures. As expected, the 2003-2005 budget had little increase in new revenues, except for a significant increase in liquor taxes.⁴ Another more minor revenue raising measure was a nursing home quality maintenance fee which was essentially a tax on nursing homes that allowed the state to increase nursing home reimbursement rates and bring in additional federal matching dollars (described below). The additional revenue received from the temporary (15 month) increase in the federal matching rate did not affect Medicaid spending decisions but rather was placed in the state's reserve account. The state, by definition, had to use the FMAP increase for Medicaid but in effect took the savings in the state share and put it in its reserve account. The argument was made that Medicaid forecasts often understated actual

expenditures and that the funds would be needed in the event of a shortfall. Offsetting these revenue measures in a small way was \$25 million in tax credits for the aerospace industry.

Essentially the budget gap was closed through reductions in spending on education, state employee compensation, and in health care spending greater than those that had been contemplated in earlier years. The state also reduced spending by a comparatively small amount (\$40 million) by the early release of non-violent prisoners and by limiting community supervision of low risk non-violent offenders following release from prison.

Spending Actions for Education and State Employees. Despite the high priority given to education, K-12 and higher education spending was cut by over \$800 million.⁵ The ballot initiatives did not call for new revenues, rather they required that the state allocate general revenues to fund these initiatives, reducing the amount of general revenue available for other purposes. The state legislature chose to slow down or suspend the implementation of these initiatives.⁶ (A two-thirds majority allows the state to amend a ballot initiative). They gave no cost of living increase to teachers with more than seven years of experience, while those with less than seven years of experience were given a cost of living increase. Salaries for new teachers were increased. The legislature also delayed their commitment to reducing class sizes. In addition, college and university budgets were reduced by \$131 million. Higher education institutions were allowed to increase tuition for resident undergraduate students by up to 7.0 percent for each year of the biennium. At the same time teachers, like other state employees, were required to pay more for health benefits.

State employees were also a major target, with cuts amounting to over \$400 million relative to baseline projections.⁷ The number of state workers was reduced by 1,100 and state employee salaries were frozen for the biennium. At the same time, state workers were required

to pay more for health insurance benefits (state payments for employee health benefits nonetheless increased by \$200 million; \$70 million was shifted to workers by increasing the employee share of cost). Finally, the state reduced the contribution to state employee pensions for a savings of \$87 million.

Health Care Spending Actions. Notwithstanding the state's commitment to health care, substantial cuts (over \$650 million) were made in both the Basic Health Plan and Medicaid.⁸ The Basic Health Plan had been budgeted to cover 125,000 enrollees and in the middle of 2003 over 118,000 individuals had enrolled. The governor proposed to eliminate 60,000 slots or about half the people enrolled in the program. The House (under Democratic control) objected; the negotiated agreement was a reduction of slots (by attrition) to allow 100,000 enrollees.⁹ A ballot initiative (I-773) approved in 2002 increased the tobacco tax by 60 cents per pack to expand the number of enrollees in BHP. It required that the state maintain BHP enrollment at 125,000 enrollees using general funds, with the tobacco revenues funding an additional 50,000 slots. Because of state budget pressures the legislature voted to use the tobacco tax revenues allocated for expanded BHP enrollment to fund current enrollees.

There was also an increase in BHP premiums and an introduction of deductibles and 20 percent coinsurance on such covered services as hospital inpatient and outpatient care, radiology such as MRIs and CT scans, and other professional services; these additional provisions also increase the likelihood of enrollment reductions. Co-payments remained for other services such as office visits, prescription drugs and emergency room visits, and there are no co-payments for preventive services and maternity care. Each member of the family enrolled in the Basic Health Plan was subject to the \$150 deductible. After the deductible was met, the health plan would pay 80 percent of costs for covered services. There was an out of pocket maximum of \$1,500 per

person per calendar year. The deductible did not count toward the out of pocket maximum. The savings from the cut in Basic Health Plan enrollment as well as deductibles and co-insurance were expected to be \$350 million.

Medicaid. The Medicaid program also was affected. Eligibility standards were not changed but the state did end the use of telephone applications and self-declaration of incomes. Further, it increased the frequency of eligibility redeterminations for children and adults from 12 months to 6 months. Reductions in enrollment were expected to save at least \$123 million. Dental care for adults, disabled, and elderly beneficiaries was also reduced.¹⁰ The governor had proposed that it be eliminated. The compromise was that adult dental care spending was reduced by 25 percent (\$12 million) by eliminating a limited set of procedures *e.g.*, root canals on back teeth. Co-payments on adult vision services and durable medical equipment were introduced.

Washington benefited from federal legislation that allowed 11 states to retain their SCHIP allotment for 1999 through 2001. In effect the state was allowed to draw down these funds by claiming federal matching funds at the higher SCHIP rate (66 percent) for children in families with incomes above 150 percent FPL (\$26 million). The state also obtain a Title XXI State Plan amendment to cover prenatal care and health services for pregnant women who did not qualify for Medicaid due to citizenship status.

The state also sought an 1115 demonstration waiver to allow it to impose premiums on children above 100 percent of poverty.¹¹ The original waiver application had also requested CMS approval to impose co-pays on higher priced drugs with generic equivalents and on the use of emergency room services, to eliminate adult hearing, vision, and non emergency dental care for adults, to use unspent SCHIP dollars to add enrollees to the Basic Health Plan, and to implement a temporary enrollment freeze on new enrollees when budget problems developed.

The latter provisions were dropped from the waiver request and the waiver was ultimately approved, in February 2004 (see below).

Payments to managed care plans and hospitals were also cut. The planned increases in managed care rates were reduced, increasing by only 1.5 percent in 2004 and 5.0 percent in 2005. These increases were lower than planned increases and accounted for \$25 million in savings. Rather than cut hospital rates, the state eliminated its state funded medically indigent program. This program provided \$100 million to hospitals for emergency room and trauma care for uninsured low-income people. This program was replaced with a smaller \$40 million grant program which was targeted to hospitals that provided a disproportionate share of care to low-income people. Hospitals remain legally obligated to serve indigent cases and it is expected that hospitals would make up the balance through other revenues. The state also tightened eligibility for its general assistance program that reduced the number of people receiving medical benefits.

Washington has also developed a preferred drug list (PDL) program for Medicaid fee-for-service beneficiaries and other state fee-for-service programs. The PDL included clinically effective drugs for which the state is able to obtain a larger discount than the federal rebate. This was expected to achieve \$46 million in savings over the biennium.

Finally, the state reduced the amount of assets that the spouse of a nursing home resident could retain from \$96,000 to \$40,000.¹² The view was that Medicaid benefits should go to the poor and a \$96,000 exemption was a benefit to the middle class. In other words, there was not much support for increasing taxes on the middle class to support a benefit for the non-poor. Washington also capped the number of home and community-based case waiver slots, and narrowed functional eligibility for personal care services. Homecare workers negotiated a contract with the state's home care quality authority for a \$2 hourly wage increase that was to be

incorporated in payment rates for home healthcare workers. The governor rejected the agreement and approved a seventy-five cent per hour increase. This smaller hourly rate increase resulted in \$67 million in savings to the state.¹³

The nursing home quality assessment fee mentioned above works as follows. Nursing homes were assessed a tax of \$6.50 per bed day on all patients, thus meeting federal requirements that provider taxes be broad based. Medicaid nursing home rates were increased by 3.0 percent and the \$6.50 was added to the Medicaid rate. The ultimate effect was that the nursing homes with largely Medicaid patients would receive more than enough revenue to offset the tax; nursing homes with few Medicaid patients would pay the tax but get little benefit from the increased reimbursement rates. Another effect was that all of the increase in the reimbursement rate was paid through federal matching funds or through the provider tax. No new state revenues were required. Thus the state received additional federal revenue and was able to increase nursing home rates for those who served Medicaid patients.

Supplemental Appropriations During the 2003-2005 Biennium

In January of 2004, the governor's budget office predicted that the state would face a \$1 billion shortfall in FY 03-05 biennium. By February, the revenue picture began to improve. As a result, in the last year of his tenure, Governor Locke made a series of proposals to address perceived needs in the state using reserves if necessary. The governor proposed to increase spending on K-12 education to support increasing enrollment and to further expand enrollment in higher education and increase scholarships for low and middle class students. The Locke administration also proposed increased payments to physicians for obstetrical care, using increased federal DSH allotments to support community-based health services, lowering

premiums for children in Medicaid scheduled to take effect in January 2004, and increasing wages of home health workers by fifty cents per hour. The proposals were criticized by Senate Republicans who opposed using reserves for these purposes and did not want to increase spending beyond what was necessary to maintain current programs. The Democratic House generally supported Locke's proposals.

The supplemental budget that was approved includes \$146 million in new spending and an additional \$173 million to cover increased numbers in public schools, in the general assistance program and in the prison population.¹⁴ There were no new tax increases but there was an infusion of \$173 million from the temporary increase in federal matching funds. All other new revenues came from state reserves.

The budget also increased enrollment in colleges and universities by 3,000 students. Governor Locke agreed to the increase of \$17 million for higher education enrollment but provided that a third of the enrollment increase to fund higher education in high demand programs would go only to public universities and colleges.

The House Democrats proposed \$25 million to cover more of the health insurance benefits costs for teachers and state employees but no funds would be appropriated for wage and salary increases. Senate Republicans proposed a small pay increase for non-teaching school employees. The final budget provided the Senate's 1 percent pay raise for non-teaching employees but not the increased health insurance coverage.

The major health care debate in 2005 was over premiums for Medicaid children above 100 percent of poverty scheduled to begin on July 2004. Despite the increased coverage of children seen in the CPS data between 2000-2003, an estimated 70,000 children in Washington lost coverage following actions taken in 2002 and 2003.¹⁵ The decline in coverage stemmed

from ending of telephone and online applications and the self-declaration of income implemented in April 2003 and the more frequent eligibility redetermination implemented in July 2003. The number of children on Medicaid fell from 341,000 in April of 2003 to 289,000 in September of 2004. After adjusting for children who transferred to other programs such as SCHIP and children who cycled back on to Medicaid, state officials estimate there was a net reduction of 39,000 children. The state is conducting a follow-up study to determine how many of these children were still eligible for Medicaid and the number who were not. In addition, Washington eliminated a state-funded program for immigrants in 2002; as a result an estimated 17,000 children lost coverage.¹⁶ The intent of lawmakers was that immigrant families would enroll in the Basic Health Plan, but most did not, seemingly because of BHP premiums. At the same time, the Basic Health Plan cut slots from 123,000 to 100,000 and increased premiums, deductibles, and co-insurance. As a result BHP enrollment fell to 95,000. The reduction was predominantly among adults though this number has been increasing recently.

The 1115 waiver mentioned above was approved by CMS in February of 2004 and permitted the state to impose premiums of \$15 on Medicaid children in families with incomes between 100 percent and 150 percent FPL, \$20 for those between 150 percent and 200 percent, and \$25 for SCHIP children and those above 200 percent FPL. The legislature agreed to impose no premiums on those between 100 percent-150 percent of poverty, reduce premiums from \$20 to \$10 per child for those between 151 percent-200 percent, and reduce premiums from \$25 to \$15 for children above 200 percent of poverty. These premiums were scheduled to be implemented in July 2004. Because of concerns over declining enrollments, the Locke Administration subsequently postponed until July 2005 the beginning of monthly premiums for Medicaid and SCHIP children with incomes below 200 percent of poverty. SCHIP premiums

increased from \$10 to \$15 per child (less than allowed under the waiver) up to a maximum of three children. The governor was able to postpone the implementation of these premiums because of lower than expected enrollment levels in Medicaid.

Grants to hospitals to reimburse for uncompensated care were increased to \$76 million, a 24 percent increase over the original biennium budget.¹⁷ The \$36 million increase in DSH payments in the 2003-2005 biennium by the federal government was allocated to state psychiatric hospitals, public hospitals, and to the Basic Health Plan, and children's Medicaid coverage. Home health workers received an additional 50 cents per hour in addition to increases in workmen's compensation and healthcare benefits. The increase of 50 cents per hour for home health workers is in addition to the 75 cents per hour mentioned earlier.¹⁸

In addition to these measure the state also froze hospital payment rates, implemented an outpatient prospective payment system expected to generate significant savings and reduced the expected growth in managed care payments. The state continued its quality assessment fees on nursing homes and expanded its preferred drug program to include additional classes of drugs. CMS has questioned the state's use of intergovernmental transfers to finance UPL and DSH programs, which are scheduled to be phased out by July 2005. The state is attempting to develop an alternative source of state funds to replace the intergovernmental transfers.

Conclusions and Outlook for the 2006-2007 Biennium

In the 2005-2007 biennium the state faces a budget shortfall of \$1.6 million.¹⁹ With no new revenues the state would be required to make substantial cuts. The governor is required by law to indicate the cuts that would be required if there were no new revenues and to make an alternative proposal that would include additional revenue. Without additional revenue, the

governor's budget would suspend further reductions in K-12 class size despite their being mandated by the voter-approved Initiative 728. The budget would also limit the number of state college students to current levels, reduce enrollment in the Basic Health Plan by 17,200, reduce spending on community health clinics, make no increases in Medicaid fee-for-service payment rates, eliminate routine dental care for Medicaid, impose premiums on children for Medicaid health coverage, and eliminate personal care services for elderly and disabled adults.

In its alternative budget the government proposed an increase in taxes on hard liquor, wine, beer, and soft drinks, raising a total of \$504 million. In addition, a new 1 percent tax on physicians would raise \$94 million and allow the state to increase physician fees in Medicaid. With the new revenue the governor would continue the class size reductions in public schools, expand enrollment in the state's colleges and universities including increases in financial aid, maintain current enrollment levels in the Basic Health Plan, expand Medicaid coverage to 16,800 more low-income children by retaining 12 month eligibility redetermination and foregoing the use of premiums, increase physician fees in Medicaid, continue providing basic dental care to low-income adults, and continue to provide personal care services to severely disabled and elderly people.

These budget choices reflect the substantial difficulty that the state faces annually. State revenues rely heavily on sales taxes and are not income elastic. The state has exhausted most alternative financing vehicles including accounting gimmicks and has made substantial cuts in aid to localities, and in compensation of state employees both wage and salaries and health benefits. The demand for support of K-12 and higher education has been growing and Medicaid costs continue to increase.

It is clear that the state will face difficult choices in the next biennium. The outgoing governor while supporting significant budget cuts during the years of heightened fiscal stress, ended his term advocating for increasing resources to health care and education and financing the increase with new revenue sources. The state's new Governor, Democrat Christine Gregorie has made health care a priority. For example, the new governor has already indicated support for returning to 12 month eligibility periods. The state now has both a Democratic House and Senate; this bodes well for the spending priorities and revenue increases proposed by Governor Locke.

Endnotes

- ¹ Urban Institute estimates from the Current Population Survey.
- ² Governor Gary Locke's 2003-2005 Budget Overview. <http://leap.leg.wa.gov/leap/budget/lbns/2003partii.pdf>.
- ³ John Holahan, "Washington" in John Holahan et al., "The State Fiscal Crisis and Medicaid: Will Health Programs Be Larger Budget Targets?," Kaiser Commission on Medicaid and the Uninsured. January 2004.
- ⁴ Governor Gary Locke's 2003-2005 Budget Overview, <http://leap.leg.wa.gov/leap/budget/lbns/2003partii.pdf>.
- ⁵ Ibid.
- ⁶ *The Seattle Post-Intelligencer*, "Divergent Views on School Funding: Administrators Breathe Sigh of Relief, Teachers Are Angry," June 18, 2003.
- ⁷ Governor Gary Locke's 2003-2005 Budget Overview. <http://leap.leg.wa.gov/leap/budget/lbns/2003partii.pdf>.
- ⁸ *The Olympian*, "What's Being Cut," July 6, 2003.
- ⁹ *The Olympian*, "Cuts to Basic Health Plan Leave Many Without Insurance," July 7, 2003.
- ¹⁰ *Seattle Times*, "Washington State Medicaid Program Cuts Some Adult Dental Procedures," July 11, 2003.
- ¹¹ *Seattle Times*, "State Sends Feds New Request for Medicaid System," August 10, 2003.
- ¹² *Seattle Times*, "Washington State Governor Considering Bill that would Decrease Amount of Assets People can Keep to Qualify for Medicaid," June 23, 2003.
- ¹³ *The Seattle Post-Intelligencer*, "\$23 Billion Budget Approved, No New Taxes; Prescription Drug Bill Also on Way to Governor Locke's Desk," June 6, 2003.
- ¹⁴ *The Associated Press*, "Highlights of Washington's Legislative Session," March 12, 2004; Senate Ways and Means Committee, "Senate 2004 Supplemental Budget Summary," February 23, 2004.
- ¹⁵ *The Seattle Post-Intelligencer*, "Number of Uninsured Children Soars," April 27, 2004.
- ¹⁶ *The Associated Press*, "Report – 17,000 Immigrant Kids Dropped Off State Health Care," May 27, 2004.
- ¹⁷ Senate Ways and Means Committee, "2004 Supplemental Budget Summary," February 23, 2004.
- ¹⁸ *The Associated Press*, "Home Care Central," March 13, 2004.
- ¹⁹ Governor Gary Locke Proposed 2005-2007 Budget: Budget Highlights. www.ofm.wa.gov/budget05/highlights.

Appendix A

List of Study Respondents

Washington

Joger Gantz, Washington Medical Assistance Administration

Jane Beyer, Washington State House of Representatives, Democratic Caucus Staff

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