

kaiser commission medicaid and the uninsured

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 bipartisan group of national leaders and experts in health care and public policy.

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Background

Since the early 1990s, Washington has been a leader among the states in efforts to expand health insurance coverage. The state extended Medicaid coverage to children 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 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 reduce the availability of general revenues for other purposes. This year for the first time the combination of the state's poor economic performance and opposition to tax increases has significantly affected health care programs.

This brief focuses on the debate over the budget enacted for the 2003-2005 biennium. In June 2003, the Washington state legislature enacted a \$23.1 billion biennium budget which closed a projected gap of \$2.7 billion.¹ 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 the ballot initiatives that required states

to increase spending on K-12 education. Other factors that contributed to the gap included higher education enrollments and rising prison populations.

The 2003-2005 Budget Debate

The 2003-2005 budget followed on the heels of a budget crisis that developed in 2002 when it became clear that the 2002-2003 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.² 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. The state also used \$325 million of the 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, reductions in assistance to cities and counties, reductions in contributions to health benefits for state employees, elimination of a 2.6 percent cost of living adjustment for state and higher education employees, reductions in public school funding, and some reductions in health care programs largely other than Medicaid.

The 2003-2005 biennium presented new problems, in part because decisions made in 2002 took some options off the table. Entering the 2003-2005 debate, legislators were faced with the difficulty of further limiting compensation of state employees. Ballot initiatives seemingly required increased spending on K-12 education. There was no

¹ Washington State 2003-2005 Omnibus Budget Overview, <http://leap.leg.wa.gov/leap/budget/bns/2003partii.pdf>.

² John Holahan, "Washington." 2003. In John Holahan et al, "The State Fiscal Crisis and Medicaid: Will Health Programs Be Larger Budget Targets?" Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

political will, even among Democrats, to increase taxes substantially. Opposition to tax increases was further enhanced when the legislature sent a referendum to the voters to approve an increase in the gas tax by nine cents per gallon. This would have raised \$750 million for the Department of Transportation, allowing them to address serious transportation infrastructure problems throughout the state. The initiative was defeated in November 2002 by a wide margin.

Higher education in principle could be a target, but demographic changes (the baby boom echo) were increasing the demand for higher education. Many of the accounting tricks and gimmicks that had been used in the past biennium had been used up. Medicaid enrollment and costs per enrollee continued to grow as did costs of the Basic Health Plan. But there was little support for cutting health programs in a major way. Most spending on health care was for children or for persons with disabilities, the medically needy, and the elderly in nursing homes. The state's Basic Health Plan, a program that covers low income working families up to 200 percent of poverty was highly popular and thought to be difficult to seriously cut. Provider payment rates were well below private and Medicare rates and could only be cut if the state was willing to risk serious reductions in access to care. With this background the state faced a set of very difficult choices in considering how to solve the \$2.7 billion budget deficit.³

As expected, the 2003-2005 budget had little increase in new revenues, the most significant being an increase in liquor taxes.⁴ Another revenue raising measure was a nursing home quality maintenance fee which was essentially tax on nursing homes that

³ State of Washington Proposed 2003-2005 Budget and Policy Highlights, December 2002, <http://leap.leg.wa.gov/leap/budget/bns/2003partii.pdf>.

⁴Ibid.

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 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 raising measures in a small way is \$25 million in tax credits for the aerospace industry. Essentially the budget gap was closed through reductions in spending on education, reductions in 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.

Education. 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 for 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

⁵Ibid.

teachers were increased. The legislature also delayed their commitment to reducing class sizes. 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. State employees were also a major target, with cuts amounting for over \$400 million relative to baseline projections.⁷ The legislature felt that with the Washington economy in dire straits state employees should not be treated better than the typical Washington worker. 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. Despite the state's commitment to health care, substantial cuts were made in both the Basic Health Plan and in Medicaid. In all, cuts in health programs were over \$600 million.⁸ The Basic Health Plan had been budgeted to cover 125,000 enrollees and in the middle of 2003 over 118,000 were 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

⁶ "Divergent Views on School Funding: Administrators Breathe Sigh of Relief, Teachers Are Angry," *The Seattle Post-Intelligencer*, June 18, 2003.

⁷ Governor Gary Locke's 2003-2005 Budget Overview, <http://www.governor.wa.gov>.

⁸ "What's Being Cut," *The Olympian*, July 6, 2003.

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 professional services, MRIs, and CT scans; these additional provisions also increase the likelihood of enrollment reductions. Co-payments remained for other services. 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.

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. The former is given credit for a significant reduction in caseload growth; the latter has yet to take effect. Reductions in enrollment were expected to save at least \$123 million. Dental care for adults, disabled, and elderly beneficiaries

⁹ “Cuts to Basic Health Plan Leave Many Without Insurance,” *The Olympian*, July 7, 2003.

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 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 sought a Health Insurance Finance Flexibility and Accountability Act (HIFA) waiver to allow it to increase 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. The state expects approval of authority to increase premiums on non-poor children with incomes above 100% of the federal poverty level.

The state commissioned an outside review of its managed care and hospital payment rates. The review suggested that managed care and hospital rates were more than adequate and could be cut. The state reduced the planned increases in managed care rates, increasing rates by only 1.5 percent in 2004 and 5.0 percent in 2005. Since these

¹⁰ “Washington State Medicaid Program Cuts Some Adult Dental Procedures,” *Seattle Times*, July 11, 2003.

increases were lower than planned increases they accounted for \$25 million in savings. The review suggested that hospital rates could be cut in the short run. But 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 which had the effect of reducing people receiving medical benefits through general assistance.

Washington has also developed a drug formulary for Medicaid fee for service beneficiaries and other state fee for service programs. The formulary included clinically effective drugs for which the state is able to obtain a larger discount than the federal rebate. This is 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 obtain 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

¹¹ "State Sends Feds New Request for Medicaid System," *Seattle Times*, August 10, 2003.

¹² "Washington State Governor Considering Bill that would Decrease Amount of Assets People can Keep to Qualify for Medicaid," *Seattle Times*, June 23, 2003.

\$2 hourly wage increase that was to be incorporated in payment rates for home healthcare workers. The governor rejected the agreement and approved a 75 cents per hour increase. This smaller hourly rate increase resulted in \$67 million in savings to the state.¹³

The nursing home quality maintenance fee described 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.

The Future

There is an expectation that there will be a small supplemental budget to keep the 2004 budget in balance. It is not expected to be a large because Medicaid spending is in line with projections primarily because caseloads for children are lower than projected, apparently because of the new enrollment tightening provisions. Spending growth in BHP is also expected to slow because of premiums and reduced benefits. Revenues are growing slowly but are in line with projections.

¹³ “\$23 Billion Budget Approved, No New Taxes; Prescription Drug Bill Also on Way to Governor Locke’s Desk,” *The Seattle Post Intelligencer*, June 6, 2003.

It will be of interest to see the public reaction to the enacted cuts such as the release of prisoners accused of drug and property crimes, the tuition increases in state universities and the suspension of the class size and teacher pay initiatives. The Basic Health Plan has been highly popular and the substantial reduction in scope may also be problematic. The premiums on non-poor children could be controversial particularly in light of the higher federal matching rate on children with incomes above 150 percent FPL. The elimination of the medically indigent program, along with reductions in Medicaid and Basic Health Plan enrollment could seriously increase burdens on hospitals that serve the uninsured. At the same time, it is clear that the opposition to revenue increases is also very strong within the state of Washington.