kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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Few Options for States to Control Medicaid Spending in a Declining Economy

Medicaid is a joint federal-state entitlement program that provides health coverage and long-term care assistance to over 45 million children and adults in low-income families and 14 million elderly and disabled people. The program is a major revenue source for safety-net providers and also fills in gaps in Medicare coverage. Medicaid is financed by the federal government and the states and is administered by states within broad federal guidelines. During an economic downturn, demand for Medicaid rises as more people fall into poverty or lose their employer sponsored coverage and become uninsured. At the same time, state revenues decline, affecting states' ability to balance their budgets and to fund programs such as Medicaid. As a result, states must grapple with increasing pressures to limit program spending in Medicaid and manage the increase of newly eligible enrollees in the program. Currently 28 states are projecting budget shortfalls for FY 2009 as states enter into another economic downturn.

Analysis of data from annual 50-state budget surveys of Medicaid directors from 2003 to 2007 conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates finds that:

States adopted a wide array of Medicaid cost containment strategies during the last economic downturn. In 2002, revenues plummeted and Medicaid spending and enrollment growth peaked resulting in state budget pressures. Every state adopted measures to control provider payments and spending for prescription drugs; these actions had immediate effects on Medicaid spending. Often as a last resort, states also turned to Medicaid benefit and eligibility cuts as well as increased co-payment requirements in an effort to control costs. Most efforts to control Medicaid long-term care spending were focused on reductions for institutional care while states continued to expand community based long-term care options.

Federal fiscal relief legislation during the last economic downturn was successful in helping to avoid deeper Medicaid cuts and to preserve eligibility. In 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act that provided $20 billion in temporary federal fiscal relief to states, of which $10 billion came in the form of a uniform increase in the federal matching rate (FMAP) for Medicaid expenditures. To receive the increased FMAP, states were required to maintain existing eligibility levels, thus helping states to avoid deep cuts and preserve eligibility.

During this economic downturn, states may have fewer policy options to control spending and may face new challenges. Beginning in 2005, state revenues were starting to recover and Medicaid spending growth hit a record low in 2006 which allowed states to restore some cuts and move forward with efforts to expand access and improve quality. As states enter another economic downturn so quickly following the previous one, provider payments remain low compared to other payers and cost controls for prescription drugs are largely in place. States have fewer options to slow spending and may need to adopt Medicaid cuts that could directly affect eligibility and coverage. Implementing comprehensive Medicaid reforms generally do not yield immediate or large savings and are typically easier to implement during favorable economic times. Complicating the economic downturn, new federal regulations could shift Medicaid costs from the federal government to the states which could worsen budget problems.

In this economic downturn, federal fiscal relief could again be used to help alleviate budget stress and support Medicaid coverage.

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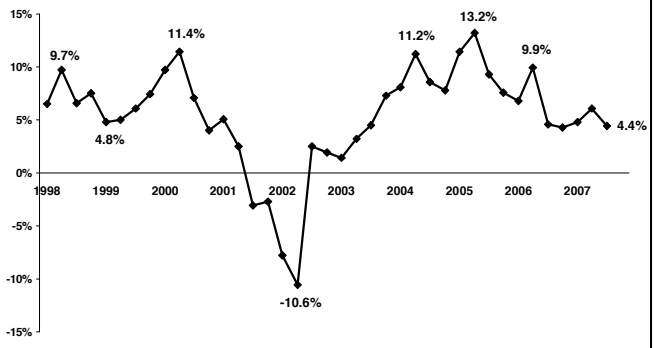
1. **State revenues fall while Medicaid spending and enrollment usually grow during an economic downturn.**

Changes in the number of people enrolled in Medicaid tend to be counter-cyclical with the economy – as state and federal revenue declines, enrollment in public programs increases. Beginning in 2001, the national economy worsened and state revenues plummeted (Figure 1). Simultaneously, more people were eligible for Medicaid as unemployment and poverty rates increased resulting in higher Medicaid enrollment and spending growth (Figure 2).

Figure 1

Quarterly State Tax Revenue Growth, 1991-2007



SOURCE: Percentage Change in Quarterly State Tax Revenue with Adjustments, National Data 1991 to 2007. *Rockefeller Institute of Government Data.* Total Nominal Change - Not adjusted for inflation or legislation.

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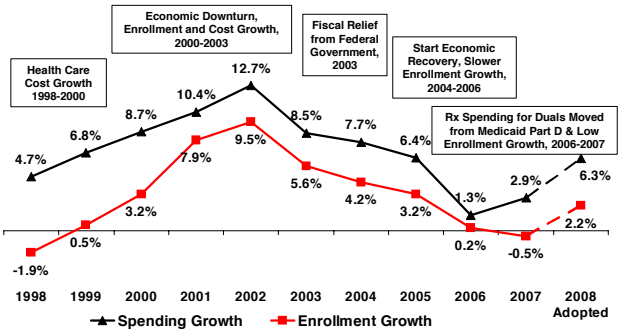
Figure 2

Percent Change in Medicaid Spending and Enrollment, FY 1998- FY 2008



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year.
SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States: June 2006.* KCMU, October 2007. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2007 and FY 2008 spending and enrollment data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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The Medicaid program is jointly funded by states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures. The federal match rate (or FMAP) is based on an annual calculation using a formula set forth in the Social Security Act. The FMAP is inversely proportional to a state's average personal income, relative to the national average. States with lower average personal incomes have higher FMAPs. This matching formula means that when states spend more of their own funds on Medicaid, they receive additional federal revenue, and conversely, when states cut Medicaid, they lose federal revenue. For example, a state with an FMAP of 60 percent must cut Medicaid by $2.40 to save just $1 in state funds.

In 2003, as health care costs continued to rise and states experienced budget shortfalls, the Federal government passed the Jobs and Growth Tax Relief Reconciliation Act that provided $20 billion in temporary federal fiscal relief to states to ease their budgetary pressures. Ten billion of this aid came in the form of an increase in the federal matching rates paid to states for Medicaid expenditures as long as states maintained existing eligibility levels, thus helping them to avoid deep cuts. FY 2005 marked the start of the fiscal recovery for many states that continued through FY 2006 when all states met or surpassed their revenue projections and most saw a slowed rate of growth in Medicaid spending and enrollment. FY 2006 represented the lowest spending growth in program history.

For FY 2008, the economic climate is expected to turn and state revenue projections are expected to slow and fall behind spending which will lead to a decline in year-end balances. Unemployment and poverty could rise resulting in likely increases in both Medicaid spending and enrollment growth.

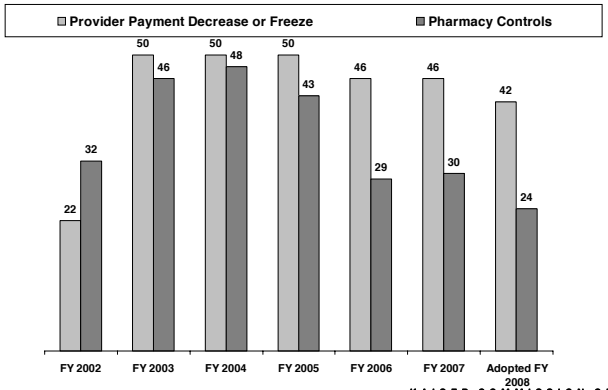
2. States adopted a wide array of Medicaid cost containment strategies during the last economic downturn, especially targeted towards provider payment cuts and prescription drug controls.

To help balance their budgets, every state implemented a variety of cost containment strategies to help control Medicaid spending growth during the last economic downturn. Every state and the District of Columbia froze or reduced provider payments (often across provider types and for multiple years) and also implemented policies to control spending for prescription drugs. The majority of states also controlled costs by restricting benefits, limiting eligibility levels, imposing new co-payments on beneficiaries or by imposing strategies to limit long-term care spending.

One common action that has an immediate effect on the budget is to decrease provider payment rates. Over the FY 2002 – FY 2008 period, every state controlled provider payment rates at least once with many states freezing or reducing rates for multiple providers and for multiple years in a row (Figure 3). Nearly every state used this strategy in 2003, 2004 and 2005. However, provider payment rates are an important factor contributing to access and availability of services for Medicaid beneficiaries. When states cut provider payment rates, some providers may decide not to participate in the program which can limit access for beneficiaries. Medicaid payment rates are typically lower than private insurance companies, so states must be careful in striking a balance between controlling spending and also maintaining adequate provider participation in the program. Medicaid directors have expressed concern about a lack of access to certain specialties such as psychiatrists and other mental health providers, pediatric specialists and dentists. While part of the issue is a general shortage of providers for these services, low Medicaid payments rates is a significant factor for provider participation and access.[1]

Figure 3

Medicaid Cost Containment Actions Over Time: Provider Payments and Pharmacy Controls



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2003 - October 2007.

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As states were entering into the economic downturn in 2001, Medicaid spending for prescription drugs was one of the fastest growing services in the program. Every state recognized this and implemented measures to control prescription drug spending. By 2007, most states had already implemented an array of policies including prior authorization, preferred drug lists and supplemental rebates, so new action to control prescription drug spending has slowed. Several states have implemented policies to impose monthly script limits or to join multi-state purchasing coalitions to control costs. Beginning in January 2006, prescription drug coverage for individuals with both Medicaid and Medicare (duals) was transitioned from Medicaid to the Medicare Part D program. This transfer shifted a significant share of prescription drug spending out of the Medicaid program, so there is also less opportunity to implement policies that would result in substantial Medicaid savings. While states are still obligated to finance a portion of these costs through a payment referred to as the "clawback" to the federal government, states cannot control these spending levels.

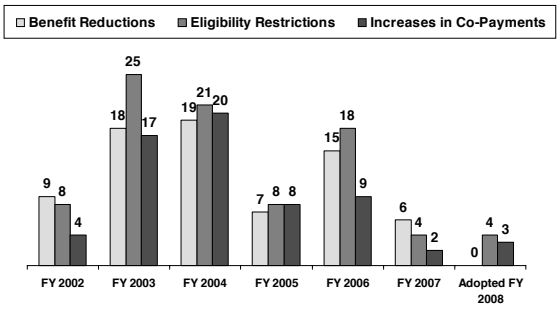
[1] Smith, Vernon, Edwards, Barbara and Tolbert, Jennifer. "Current Issues in Medicaid: A Mid-FY 2008 Update Based on a Discussion with Medicaid Directors." KCMU, January 2008.

3. Often as a last resort, states also turned to Medicaid benefit and eligibility cuts as well as increased co-payment requirements in an effort to control costs during the last economic downturn.

Due to their direct negative impact on beneficiaries, states typically restrict benefits, eligibility and co-payments only as a last resort method to control costs in their Medicaid programs (Figure 4). During the last economic downturn, many states needed to implement some of these initiatives to manage programmatic spending. Because such a small share of beneficiaries account for such a large share of Medicaid expenditures, states need to make very deep eligibility and benefit cuts for relatively healthy populations to generate even small savings. Alternatively, smaller cuts in eligibility or benefits for high cost populations could generate more substantial savings, but could have serious negative consequences for very vulnerable beneficiary groups that have no other options for coverage or access to services outside of Medicaid.

Figure 4

Medicaid Cost Containment Actions Over Time: Benefits, Eligibility and Co-Payments



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2003 - October 2007.

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Eligibility. As a condition for receiving the enhanced federal Medicaid matching rate during the last recession, states were required to maintain eligibility levels that were in place in 2003, limiting these types of cuts. While required to maintain eligibility levels, some states made it more difficult for beneficiaries to obtain or maintain Medicaid coverage by increasing administrative or procedural barriers related to the Medicaid application process in an effort to control costs.

After the period of federal fiscal relief ended, a few states pursued major Medicaid eligibility cuts while others began to restore some of the cuts or barriers imposed during the worst part of the economic downturn. For example, Tennessee and Missouri made significant eligibility cuts to their programs in 2006. Tennessee scaled back coverage for adults that were part of the TennCare waiver which affected over 200,000 individuals. Missouri scaled back coverage for low-income parents on Medicaid and went from being one of the states with the highest eligibility for low-income parents at 75 percent of poverty, to one of the lowest at about 23 percent of poverty. At the same time, states like Connecticut restored some eligibility cuts for parents and Washington state removed some procedural barriers to enrollment that were imposed during the toughest fiscal times.

Benefits. Many states did turn to benefit cuts. In most cases these cuts were targeted to optional benefits such as vision, dental and therapeutic services primarily for adult populations. Many of these cuts proved to have negative implications for beneficiaries. As a result of cuts to dental services in Massachusetts in 2002 and 2003, 100,000 fewer adults in MassHealth received dental benefits in 2004 compared to 2001, MassHealth reimbursement for dentists declined, community health centers did not have the capacity to deal with the large number of new patients, and beneficiaries reported an increase in untreated dental problems and described living in pain.[2]

[2] Pryor, Carol and Monopoli, Michael. "Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience." Report for KCMU. September, 2005.

Cost Sharing. A number of states imposed cost-sharing requirements on beneficiaries as a strategy to control costs. A significant body of research shows that while cost sharing may reduce Medicaid spending, even small amounts of cost sharing can create barriers for access to care particularly for low-income populations.[3] In Oregon, increased premiums and stricter payment policies in their Oregon Health Plan Waiver program led to large enrollment drop offs and most people who were disenrolled became uninsured. Also, new copayment requirements and benefit limits created barriers to accessing needed care.[4]

Structural Reforms. States also pursued structural reforms often to save money; however, these reforms are not likely to produce immediate savings. In 2006, the Deficit Reduction Act (DRA) was signed into law and contained provisions relating to eligibility and changes in Medicaid policy with regards to both benefits and cost sharing. Currently eight states have opted to use the new DRA flexibility around benefits. Kentucky, West Virginia and Idaho moved quickly to take advantage of the new flexibility to do a comprehensive redesign of their Medicaid benefits. These states had been in the middle of developing plans for comprehensive Medicaid reform using the 1115 Waiver process which required a long process of planning and negotiating at the state level, so they were uniquely positioned to use the new DRA options instead of seeking a waiver. These states all expected Medicaid cost savings as a result of the reforms. An audit report in December 2007 stated that despite claims that the KyHealth program would save between $120 and $130 million a year, there were no reports to substantiate Medicaid savings. The audit also stated that reporting reforms were necessary to make informed decisions about Medicaid programs and decisions.[5] Florida implemented a comprehensive Medicaid reform waiver in two pilot counties that was designed to generate some Medicaid savings; however, there is not sufficient data yet to determine the effects of the waiver for various populations or for state Medicaid spending.

While savings may accrue over time, these types of structural reforms are not likely to produce immediate or large budget savings. Additionally, it is generally easier to implement and gain support for these types of structural reforms during a positive fiscal climate, rather than during a downturn.

[3] Hudman, Julie and Molly O'Malley, "Health Insurance Premiums and Cost-sharing: Findings from the Research on Low-Income Populations," KCMU. March 2003

[4] Artiga, Samantha and O'Malley, Molly. "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experienes." KCMU. May 2005.

[5] State Auditor Crit Luallen Releases Review of Medicaid Changes: No Clear Determination of Cost Savings Possible Under Current Reporting; Eleven Recommendations for Improvement. December 17, 2007. http://www.auditor.ky.gov/Public/Audit_Reports/Archive/2007AMedicaidPerformancereport-PR.htm

4. **Most efforts to control long-term care spending were focused on reductions for institutional care while states continued efforts to balance long-term care systems and expand community based long-term care options.**

Over the past several years a growing number of states have taken action to balance their long-term care delivery system by reducing reliance on institutional services and increasing access to home and community-based service (HCBS) options. Therefore, most efforts to control long-term care costs were focused on strategies targeted to institutional care providers such as reducing available nursing home beds and reducing payments for bed holds. Overall, states were expanding community based long-term care options, even during the economic downturn, however, some states imposed utilization controls on HCBS programs or further limited the number of available HCBS waiver slots to control costs. Medicaid is the primary source of coverage and support for individuals with disabilities and many long-term care services are typically not covered by private health insurance or by Medicare. So, often Medicaid cuts to long-term care services can have a significant impact on the availability of long-term care supports that are available in the marketplace. Some long-term care delivery changes may prove to be cost effective, but over a longer period of time. These changes are not likely to generate immediate fiscal savings for states.

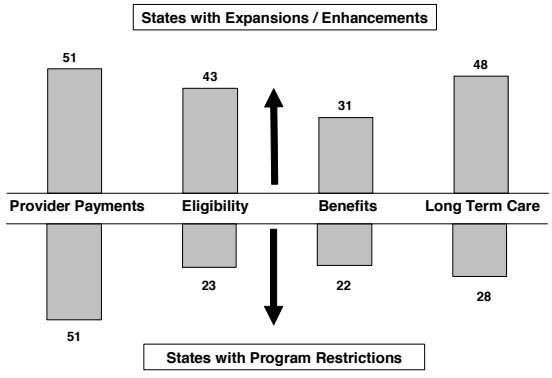
Even through the last economic downturn, states were expanding community based long-term care options by adopting new (or expanding old) HCBS waivers. In 2006, the DRA presented options for states to have increased flexibility to deliver long-term care services and supports and to expand the role of private long-term care insurance. The DRA also imposed new requirements related to asset transfers that would make it more difficult for individuals to be eligible for Medicaid financed nursing home care.

5. **States remained focused on controlling Medicaid spending, but were able to restore some cuts, adopt new measures to expand access to coverage, and improve quality when the economy began to recover starting in 2005.**

Beginning in 2005, states and the federal government began to see an improvement in the fiscal climate. State revenues were generally stronger and by 2007 states were able to restore cuts that they had made to their programs and formulate plans to expand Medicaid to address the growing number of uninsured. Since this time, states continue to focus on strategies to control Medicaid costs but the actions are not as far reaching in scope. For example, states are now more likely to increase provider payment rates, eligibility levels, benefits offered and long-term care delivery options. In the last budget survey conducted in the summer of 2007, states recognized that restoring some provider rate cuts and more generally enhancing Medicaid provider rates was essential if they were to be able to build on Medicaid to cover more uninsured and ensure access to providers. No states planned on making benefit reductions in 2008 and more states have started to increase

Figure 5

State Policy Actions Over Time FY 2005 – FY 2008*



NOTE: Includes FY 2008 Actions that have been adopted and not necessarily implemented

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2003 - October 2007.

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benefit plans and expand eligibility to address the growing number of uninsured.[6] Additionally, states were able to continue to focus on balancing long-term care systems and increase access to community based long-term care options (Figure 5). Many states have kept in place efforts to control prescription drug spending that were first implemented during the last economic downturn.

In addition to seeing fewer cuts and more restorations and expansions, states have also been able to focus more seriously on strategies to improve the delivery and quality of care for beneficiaries. Many of these efforts may increase the "value" of the state Medicaid spending and may have longer term quality and savings implications. Some of these efforts include instituting performance measures for these providers, adding disease management programs to coordinate care for beneficiaries with chronic conditions, and enhancing efforts to detect fraud and abuse in their programs as well as expanding managed care delivery systems.

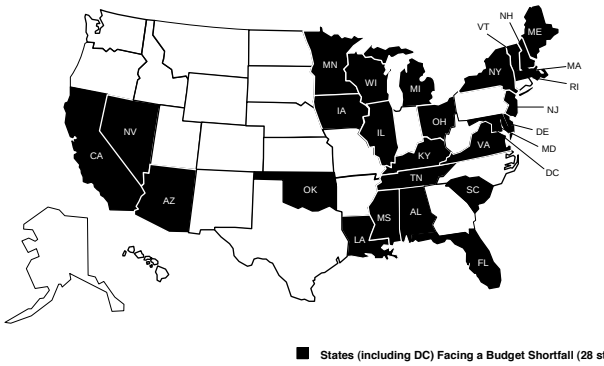
6. As states enter into another economic downturn, cost containment strategies that were effective in the last downturn will be less available so states may turn to core Medicaid program cuts that could directly affect beneficiaries.

While states had a positive outlook in 2007 and planned for expansions in fiscal year 2008, the economic situation is continuing to worsen and many states are faced with a need to control costs once again and implement cuts in order to balance their budget. Specifically, tax revenues are continuing to decline with 28 states currently reporting budget shortfalls (Figure 6). Budget shortfalls in 22 of these states and the District of Columbia could total as much as $39 billion.[7]

During the last economic recession, states experienced a loss in tax revenue and greater levels of unemployment, but forecasters for this downturn are predicting greater pressures on states with the additional burden of high energy prices and a faltering real estate market. Similar to the last downturn, this current recession will likely result in a growth in Medicaid enrollment and spending that will continue as unemployment increases and employer sponsored coverage declines.

Figure 6

Over Half of States Facing a Budget Shortfall in FY 2009



SOURCE: Based on a study conducted by the Center on Budget and Policy Priorities, 2008

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As states enter this downturn, cost containment strategies that were effective in the last downturn will be less available. Medicaid provider payments are already lower than other payers and rates were cut or frozen in the last downturn. States will find it difficult to cut rates below current levels without risking the effects of diminished provider participation and beneficiary access issues. Similarly, many states moved aggressively to control prescription drug spending during the last downturn, so new efforts in this area will have a marginal effect on

[6] Smith, Vernon, et al. "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008." KCMU, October 2007.
[7] McNichol, Elizabeth and Iris Lave. "22 States Face Total Budget Shortfall of At Least $39 Billion in 2009; 8 Others Expect Budget Problems." Center on Budget and Policy Priorities. April, 2008.

Medicaid spending. In the last downturn, states turned to core program cuts related to eligibility levels and benefits as a last resort, but they may need to consider these reductions sooner to meet budget constraints. While few states have opted to use new flexibility around benefits and cost sharing that were included in the DRA, more states may consider these options in an effort to reduce Medicaid spending.

7. Looking forward, new federal regulations could shift Medicaid costs from the federal government to the states adding to budget problems; however, Congress could provide federal fiscal relief to help alleviate budget stress and protect Medicaid programs.

At the same time as states are experiencing budget shortfalls, the Administration has promulgated a series of regulations designed to limit federal Medicaid spending which could shift more than $12 billion in federal Medicaid spending to states over the next five years, and the President's FY 2009 proposed budget called for new policy changes that could reduce federal Medicaid spending by more than $17 billion over the next five years. Despite the economic downturn and the federal policy hurdles, many states remain committed to addressing the growing number of uninsured. Maintaining current programs and expansions become much more difficult with limited resources especially since states must balance their budgets. Congress may once again consider Medicaid fiscal relief to states which proved to be a successful strategy to both help the states and preserve needed Medicaid coverage during the last economic downturn.

The length and depth of this economic downturn, the outcome of pending federal regulations and the availability of federal fiscal relief will play a large role in determining how Medicaid programs and the individuals served by the program will fare during this downturn. Additionally, budget conditions will also affect state's ability to maintain and expand Medicaid coverage to address the growing needs of the uninsured.

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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.