THE KAISER COMMISSION ON
Medicaid and the Uninsured

Summary of Findings

States' Fiscal Status and Actions to Slow Medicaid Spending

Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006 (Pub#7392), is based on a survey conducted by KCMU and Health Management Associates in July and August 2005, at the end of most states' 2005 fiscal year and the start of FY2006. States experienced a 4 percent enrollment growth in FY2005 and expect 3.1 percent growth in FY2006. If the FY2006 projection becomes reality, it would be the slowest rate of growth since FY1999 and the fourth consecutive year of slowing, but still positive enrollment growth. Increasing poverty and the erosion in private insurance coverage remain factors contributing to enrollment growth in public coverage programs.

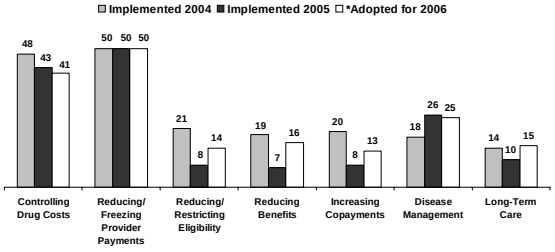
Since FY2002, the three top factors driving Medicaid spending cited by state Medicaid officials have remained consistent, but the order has shifted. For FY2006, states ranked increasing health care costs as the most important, then enrollment growth, and finally prescription drug costs. Enrollment and prescription drug costs previously got top ranking.

All 50 states and DC implemented Medicaid cost control strategies in FY2005. Controlling drug costs and reducing or freezing provider payments are the most prominent strategies. One sign of the improving outlook for states was the significant decline from FY2004 in the number of states implementing eligibility and benefit cuts and increases in copayments. For FY2006, states indicated they were planning new cost containment actions in the face of continuing budget pressures. See Figure 1. However in FY2005, states planned more cost containment actions than they actually implemented; similarly some planned actions for FY2006 may not be implemented due to challenges to them or positive changes in state revenue projections. Twenty five states plan to implement a new Section 1115 waiver or amend an existing waiver in FY2006 with 13 of those states saying the primary goal is to reduce growth in Medicaid costs.

States actions in FY2005 and those proposed for 2006 are more expansive than in previous years. At least one provider rate increase was implemented by 47 states in FY2005 and adopted in every state for FY2006 in part to address concerns over access to physician care. States also implemented eligibility expansions or application simplifications (20 in FY2005 and 22 in FY2006) and adopting long-term care expansions (11 states in FY2005 and 25 states in FY2006), with most related to home and community-based services. See Figure 2.

Figure 1

States Undertaking New Medicaid Cost Containment Strategies FY 2004 – FY 2006



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004 and October 2005.

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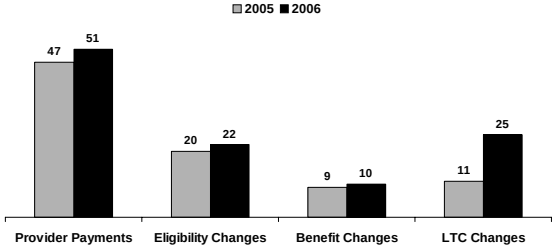
Figure 2

States Undertaking Increases/Expansions in FY 2005 and FY 2006



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2005.

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This year Medicaid officials expressed more optimism than in past years about the future of Medicaid, but remain concerned about the long-term fiscal sustainability of the program due to continuing health care cost growth, demographic trends, and the erosion of private health insurance. With no systemic solution to address the growing uninsured population and the lack of alternatives for long-term care assistance, Medicaid is the current policy answer. The challenges and responsibilities associated with the implementation of the new Medicare prescription drug benefit add to the concerns. Federal efforts to control Medicaid spending leave state officials uneasy about the possible shift of more financing responsibility for the program to the states.

One state official summed up state concerns:
"The issue for us is, will we have enough funds to do the job we are asked to do?"

State Management of Medicaid Prescription Drug Benefit

State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update (Pub#7381) is a survey of states on Medicaid prescription drug policies in the first half of 2005 conducted by KCMU and Georgetown University's Health Policy Institute. Thirty six states and the District of Columbia responded to the survey. While all surveyed states are actively managing their prescription drug benefit, there is diversity across states in how cost control mechanisms are applied.

States are using an assortment of cost management tools, including preferred drug lists, prior authorization, required use of generics, copayments, and limits on prescriptions. While most states have dispensing limits, most of these limits are soft limits in which individuals can still receive prescriptions with prior authorization or clinical justification. Only 2 of the responding states automatically denied refills and only 4 automatically denied new prescriptions exceeding state-imposed limits. Although all surveyed states require prior authorization, the process only applies to an average 7.5 percent of all Medicaid drug spending in the surveyed states and only 3.4 percent of all claims on average require prior authorization.

State officials expressed concern about the impact of the new Medicare prescription drug benefit in 2006. As many of Medicaid's high cost users of prescription drugs, who are dually eligible for Medicaid and Medicare, will transition to the new Medicare benefit. Eight of 11 states feared that they will receive a smaller Medicaid rebate from pharmaceutical manufacturers due to a loss in market share.

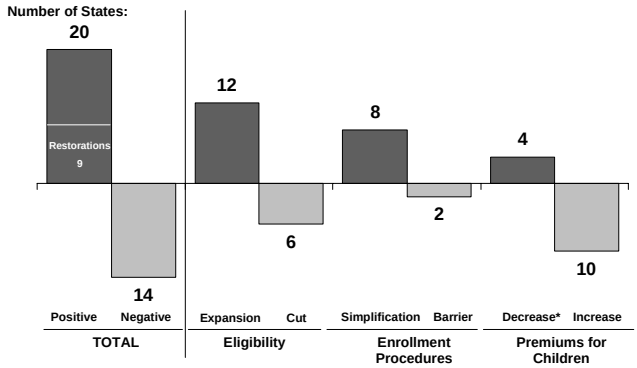
Increased Interest in Simplification and Expansion, But Also Higher Cost Sharing

In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families (Pub#7393), a survey of state officials by KCMU and the Center on Budget and Policy Priorities reflects state actions from July 2004 until July 2005, provides more evidence that states are coming out of their fiscal crisis as they are taking more actions to simplify procedures and requirements for beneficiaries and, in some cases, expand eligibility.

Twenty states took actions to expand access to health coverage by expanding eligibility, adopting procedural simplifications, or reducing premiums for children's coverage. Twelve states expanded eligibility for children, pregnant women, or parents—Illinois, Virginia and Wyoming expanded for the second straight year. Eight states adopted simplifications for enrollment or retention of coverage. In nine states, these actions reversed previous cuts. Compared to the previous year, fewer states took actions that can make it more difficult for eligible children and parents to secure or retain health coverage. In 10 states, premiums imposed on low-income families for their children's health coverage have increased and, in some cases, are targeted to lower income families than in the past. See Figure 3.

Figure 3

State Policy Decisions on Eligibility, Enrollment Procedures, and Premiums for Children and Families in Medicaid and SCHIP, July 2005



*Decreases includes one state which reduced premiums for children and three states which reduced or eliminated their lock-out periods for non-payment of premiums.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

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The sharp disparity between the level of eligibility for children and parents persists. While most states maintain eligibility for children at 200% of the federal poverty line or higher as of July 2005, in half the states, a parent in a family of three working full-time at the federal minimum wage who earns $893 per month ($206 per week) cannot qualify.