Health care's dual crises

Officials will tackle spiraling Medicaid costs and medical malpractice reform at CSG meeting

BY TRUDI MATTHEWS

Two health care issues are dominating state legislatures in 2003: Medicaid spending and medical malpractice reform. At CSG's 2003 National Committee and Task Force Meetings on May 15-17, CSG's Health Task Force will consider solutions to both of these challenges.

Controlling spiraling Medicaid costs

Medicaid now represents more than 20 percent of state spending, second only to education, and is growing faster than any other portion of state budgets. The Centers for Medicare and Medicaid Services report that Medicaid spending grew 10.8 percent in 2001, caused in large measure by an 8.5 percent rise in enrollment. Meanwhile, the economy grew at a meager 2.6 percent. Estimated growth rates for 2002 and beyond are also cause for alarm. In 2002, Medicaid costs increased about 13 percent, according to estimates by the Kaiser Family Foundation. Congressional Budget Office projections place Medicaid cost growth at around 9 percent per year for the next 10 years.

Medicaid costs have risen dramatically for a number of reasons. With the economic downturn, enrollment growth has been a leading driver of the increases. Like in the private sector, the retreat from managed care as a cost containment tool has also been a significant factor in cost growth. Hospitals and health plans are simply charging more for the same services. Prescription drug costs have been one of the fastest-growing portions of the health care dollar, growing at double-digit rates since 1995. In addition, because Medicaid is the largest payer for long-term care, states have been struggling with increases in nursing home and home- and community-based services.

State officials looking for answers to budget problems may be surprised by some of Medicaid's unique features that make cost containment difficult. Medicaid covers many, but not all, of the nation's poor, including women and children, the disabled and the elderly. Although families and children make up more than 70 percent of enrollees, they account for less than 30 percent of spending.

The elderly and disabled populations, meanwhile, make up a little more than 25 percent of enrollees but account for more than 70 percent of program costs. The dual eligibles, a subset of the elderly and disabled population covered through both Medicare and Medicaid, account for about a third of Medicaid spending. Because the elderly and disabled often have more complex health care needs, they use health care services more intensively than the privately insured population.

States must work within federal guidelines for their Medicaid programs and are required to submit state plans to the U.S. Department of Health and Human Services for approval. If they wish to deviate from federal rules, states must file a waiver and receive federal approval, a process that can take months or years to complete.

States and the federal government jointly fund Medicaid, with the federal government match ranging from 50 percent to 80 percent of the program's cost. Wealthier states receive lower federal matching payments. On average, states contribute 43 percent of the program's cost. In times of fiscal stress, the joint financing of Medicaid can result in a double whammy for states. States must cut $1 or more of Medicaid spending to save 50 cents. State cutbacks hurt even more because they result in additional loss of federal funding.

A recent survey by the Kaiser Commission on Medicaid and the Uninsured found that states are using a number of strategies to contain costs, including provider rate cuts, prescription drug controls, eliminating benefits, reducing eligibility, increasing cost sharing, and maximizing federal matching funds. Going into fiscal year 2004, however, the financial situation has caused states to look at steeper cuts.

Medicaid restructuring

The states' grave fiscal situation is causing policy-makers at both the state and federal levels to take a new look at Medicaid and consider the program's future direction. Although officials from different parties see Medicaid's problems in different ways, generally, state leaders have asked the federal government to give states either greater funding, more flexibility or both.

Some state leaders have called on Congress and the administration to increase the Federal Medical Assistance Percentage as a way to counter the effects of the recession. Many state leaders have also supported a Medicare prescription drug benefit, for the relief it would provide to seniors as well as beleaguered state budgets. Other proposals have called on the federal government to assume control for the financing of care for the dual eligible population.

The administration has announced its own proposal, which would dramatically restructure the relationship between the federal government and the states with regard to Medicaid. Health and Human Services Secretary Tommy Thompson proposed an optional plan for states that would give them flexibility to redesign eligibility and benefits for optional groups without filing a waiver. Participating states would receive additional funds over the next three years, with funding tapering off in the remaining seven years of the plan. States would still be required to continue services for mandatory populations in the same way as before.

At the May meeting, CSG's Health Task Force will consider setting up a working group on Medicaid restructuring. The group would be charged with developing a set of consensus principles for transforming Medicaid into a 21st century vehicle to provide health care coverage to lower-income individuals. It would report back its findings to the Health Task Force and CSG's leadership.

Tackling medical malpractice reform

The other big issue states are examining is medical malpractice reform. Against the backdrop of news stories of doctors walking off the job, protesting high insurance premiums – or even shutting down their practices – state officials are grappling with how to make malpractice insurance more affordable.

The current crisis replicates similar predicaments of the 1970s and 1980s. Yet, states that enacted reforms following those events are not necessarily inoculated from a crisis now.

Much of the problem with the malpractice market lies with the volatility of a market economy. When the economy is good, insurance companies use their investment income to minimize premium increases and may even underprice premiums to gain a greater share of the market. When the economy sours, however, insurers cannot keep premiums artificially low through other revenue sources.

Many analysts agree that the legal system is an inefficient method of providing compensation for medical malpractice. Many victims never file claims or receive only a fraction of the compensation they need. The court system is also unpredictable, costly, time-consuming and does little to prevent injuries from happening. In addition, more than half the cost of medical malpractice cases is related to determining fault.

Underlying all the increases in medical malpractice premiums is the fact that the health care system is far too prone to error. Recent reports from the Institute of Medicine determined that as many as 98,000 deaths may occur each year because of medical errors, that many of these errors are preventable and that there are ways to improve the health care system's quality.

At CSG's 2003 National Committee and Task Force Meetings in May, leading experts will discuss medical malpractice. Speakers will provide an overview of the related issues and look at various models for reforming the medical malpractice system.

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