



Rising Medicaid costs test state-federal partnership

by Tim Anderson

Just as they share in the financial burden of increased Medicaid costs, states and the federal government also share concerns about the program's future.

Now in its 40th year, Medicaid has evolved into the nation's largest health insurance program, providing coverage to more than 52 million low-income, disabled and elderly Americans.

The price tag has grown as well. Medicaid is consuming a larger and larger share of state expenditures, accounting now for nearly a quarter of state budgets.

"Unless we can control the costs of Medicaid, it will eat our budget alive," says Kansas Sen. Jim Barnett, a Republican from Emporia.

State lawmakers around the country are expressing similar concerns.

Meanwhile, the federal government is paying even more. About 57 percent of Medicaid funds come from Washington, D.C., and close to half of the federal dollars sent to states are earmarked for costs related to the program.

In all, Medicaid makes up about 13 percent of mandatory spending in the federal budget. According to a recent Congressional Budget Office report, program expenditures increased by about 10 percent over the past two years. Similar rates of growth at the federal level are expected in the future.

As a result, 2005 not only marks the 40th anniversary of the program. It also is a year in which state and federal lawmakers appear more resolved than ever to pursue Medicaid reforms.

Search for solutions

As evidenced by rising expenditures in the private health insurance market, the increasing cost of Medicaid is partly beyond the control of policymakers. Many factors (new technologies and drugs, greater use of pharmaceuticals, an aging population, etc.) have caused an increase in national health care spending, which now makes up 15.5 percent of the U.S. gross domestic product.

But health care expert Kathleen Gifford says the cost of Medicaid also has increased because policymakers have decided to expand its reach.

✦ Ideas in Medicaid reform ✦

This is the third of a three-part series examining the state-federal Medicaid program. The first article examined an innovative plan in Iowa to expand and improve its program. The second part focused on states' Medicaid cost-containment strategies.

"If there is a niche health care problem that the feds want to address, like breast cancer or cervical cancer, they'll turn to Medicaid," says Gifford, a principal at Health Management Associates, a health care research and consulting organization.

"And if states want to solve a health care problem, they're going to first look to Medicaid because it can bring federal matching dollars with it."

Because the states and federal government share in the program's costs, she says, they are encouraged to use it to meet health care needs.

Higher Medicaid expenses have resulted in greater scrutiny over the program. That, in turn, can cause friction in the state-federal partnership.

"There's a constant tug of war going on," says Greg Moody, a principal for Health Management Associates. "The states want flexibility. But then there's a skepticism at the federal level that states will use the flexibility to generate money for other things."

Some of those financing issues have come to a head this year.

The single largest cut in President George Bush's proposed fiscal

year 2006 budget was Medicaid. The plan called for saving \$60 million in federal costs over the next 10 years, largely by eliminating various financing mechanisms used by states to secure additional dollars from Washington.

He proposed offering more Medicaid flexibility to states in return and introduced longer-term reforms as well. But the cuts concerned state lawmakers, who said the loss of federal funding would compound their budget problems and threaten the health care coverage of low-income residents. The U.S. Senate agreed. Its version of the budget rejects many of the proposed reductions.

The U.S. Department of Health and Human Services has since formed a Medicaid commission. By Sept. 1, the commission will deliver

recommendations on how to achieve \$10 billion in program savings over the next five years.

NGA's ideas for reform

Meanwhile, the nation's governors have intensified their lobbying efforts. In recent months, leaders of the National Governors Association have testified before the U.S. Congress and introduced a preliminary report on how to reform Medicaid.

The NGA says its recommendations would strengthen and streamline the program while also providing states with more flexibility. The bipartisan organization's ideas include:

Cutting prescription drug costs — The NGA proposes increasing the rebates states receive on generic and brand-name pharmaceuticals from manufacturers; developing policies that increase the use of more-affordable generic drugs; and creating a tiered, enforceable co-pay structure for beneficiaries.

Asset policy reforms — To encourage individuals and their families to self-finance long-term care, rather than use Medicaid, the NGA wants to increase the penalties for inappropriate asset transfers and restrict the types of assets that can be shifted. It also wants to encourage the use of reverse mortgages to pay for long-term care services. The NGA proposes that any person who obtains a reverse mortgage be able to shelter \$50,000 in equity from his or her house.

More flexibility for states — Under NGA's proposal, Medicaid would be modified to look more like the State Children's Health Insurance Program, which gives states broad discretion to establish enforceable premiums, deductibles or co-pays. The NGA notes that these new cost-sharing provisions should be balanced with financial protections for beneficiaries, who would not be required to pay more than 5 percent of their total household income. The NGA also wants more flexibility in the kinds of benefits that states can offer different Medicaid populations. Another recommendation would make it easier for states to seek and obtain federal Medicaid waivers.

Parts of the NGA plan are similar to what Bush introduced earlier in the year. He has proposed a stronger regulation of "questionable asset transfers" along with more flexibility for states in areas such as cost-sharing and the scope of services provided to Medicaid recipients.

The states and federal government also agree on the need to address the financial drain that long-term care costs are having on Medicaid. Both want to encourage a greater use of home and community-based services and expand long-term care partnership programs. Through these programs, consumers who purchase long-term care insurance can become eligible for Medicaid services after their insurance coverage is exhausted, without having to divest all of their assets. ✦

Federal Medicaid spending in the Midwest for fiscal year 2004

State	Total (\$ in millions)	Per capita	Matching rate*
Illinois	\$6,115	\$481	53.0%
Indiana	\$3,222	\$517	65.3%
Iowa	\$1,542	\$522	66.9%
Kansas	\$1,251	\$457	63.8%
Michigan	\$5,193	\$514	58.8%
Minnesota	\$2,906	\$570	53.0%
Nebraska	\$968	\$554	62.8%
North Dakota	\$371	\$585	71.3%
Ohio	\$7,511	\$655	62.2%
South Dakota	\$432	\$561	68.6%
Wisconsin	\$2,829	\$513	61.4%
United States	\$184,382	\$627	—

* The matching rate, or Federal Medical Assistance Percentage (FMAP), determines the amount of federal matching funds delivered to each state for Medicaid-related expenditures.

Source: Kaiser Family Foundation