Adding to state budgetary woes is the tremendous growth in health care spending. The Centers for Medicare and Medicaid Services (CMS) reported that health care costs overall grew by 8.7 percent in 2001 from the previous year, and that Medicaid spending grew 10.8 percent, caused, among other things, by an 8.5 percent rise in enrollment.1 This growth far outpaced the economy, which grew only 2.6 percent. Worse still, the projections for 2003 and beyond paint a gloomy picture. In 2002, final figures for Medicaid cost growth are expected to come in around 13 percent.2 Congressional Budget Office projections place Medicaid cost growth at around 9 percent for the remainder of the decade.3

In this bleak picture of health care cost growth, Medicaid stands out as the program hit hardest by the economic downturn and rising health care costs. Governors, legislative leaders and Medicaid officials around the country see Medicaid’s current cost trajectory as unsustainable in both the short-term and the long-term.4 Threatened by the runaway trains of rapid health care inflation and stagnant state budgets, Medicaid unfortunately has few brakes able to slow its growth, outside of throwing people off the rolls and simply paying less for the same services. Looking ahead, the aging of the population coupled with consumer insistence on unrestrained choice of providers and treatments spells disaster for cost containment efforts in the future. Yet, states have been here before. As in previous eras of runaway cost growth, state leaders are marvelously adept at developing their own coping mechanisms, especially with regard to Medicaid. There are already emerging trends in state responses to the Medicaid crisis that may indicate the future direction of Medicaid policy.

Medicaid’s Past

Medicaid is an incredibly complex program due to its mix of beneficiaries, joint funding and differing features from state to state. Understanding the program’s past can help explain some of the unique challenges Medicaid faces currently and into the future.

Medicaid covers many of the nation’s poor and most vulnerable citizens, including women and children, the disabled and the elderly. Because of Medicaid’s unique structure of funding and control by both the federal government and the states, state policymakers face a complex political landscape that makes cost containment more difficult than is available to the private sector. Federal requirements limit the scope of state action concerning eligibility, cost-sharing and other program features. In addition, Medicaid enrollees often have more complex health care needs and are, therefore, more expensive to treat.

Title XIX of the Social Security Act established Medicaid in 1965. A kind of afterthought during legislative discussions of Medicare, Medicaid was designed as a means-tested program to serve certain low-income groups, or “categories,” of people receiving cash assistance from the government – primarily women and children on welfare. Medicaid also provided supplemental coverage for low-income disabled and elderly individuals receiving Social Security assistance.5 At the time it was enacted, Medicare was designed to provide only hospital and physician services coverage for seniors. In a curious accident of history, long-term care, prescription drugs and a host of other services for the low-income elderly were placed within Medicaid, not Medicare. The decision to bifurcate coverage for the low-income elderly and disabled between the two programs seems odd to observers today. However, at the time, few health insurance plans provided comprehensive coverage for items such as prescription drugs. But this decision has greatly affected the prospects for uncontrolled cost growth within Medicaid.

Medicaid was also designed as a program jointly funded and controlled by both the federal government and the states. Each state administers its Medicaid program within federal guidelines and receives federal matching funds of 50 to 80 percent of Medicaid’s cost. The federal government mandates that certain categories of individuals and certain services be covered by the states. Mandated services under Medicaid include inpatient and outpatient hospital, physician care, lab and x-ray and long term care services, among others. States can also opt to cover additional populations and services and receive federal matching funds for these benefits. Among the optional benefits that states frequently cover are prescription drugs, hearing aids, dental care and vision care.6
These features of Medicaid mean that it is very different from other health insurance programs and that these differences have important implications for cost containment. First, Medicaid is not just one program, but actually 56 different programs, each one very different depending on the state or territory administering it. Each state must cover certain categories of individuals that fall within certain income guidelines, but every state has taken advantage of federal matching funds to extend coverage beyond the minimum guidelines. Second, states spend most of their Medicaid money on providing health care to the elderly, blind and disabled populations, rather than women and children. While families and children make up more than 70 percent of Medicaid’s 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 Medicaid’s program costs. This is true despite the fact that many of the low-income elderly and disabled are “dually eligible,” receiving coverage through both Medicare and Medicaid. This small dual eligible population is responsible alone for 35 percent of Medicaid spending. Trends in elderly and disabled enrollment combined with the role of Medicaid in providing coverage for these populations mean that Medicaid cost growth will continue to outstrip overall economic growth rates significantly, even if the economy rebounds.

Finally, joint control of the Medicaid program means that it has neither the uniformity that one might expect from a federally sponsored program nor the complete flexibility that state leaders would like in order to fit each state’s needs. States must follow broad federal guidelines for their Medicaid programs, but there is substantial program variation across states. States are required to submit state plans to U.S. Department of Health and Human Services for approval. If they wish deviate from federal rules governing the program, states must file a waiver and receive federal approval, a process that traditionally has been both politically and administratively complex and time-consuming.

Medicaid represents now more than 20 percent of state spending, second only to education in state budgets. To harried state leaders responsible for balancing the state’s budget, Medicaid’s joint control and financing can seem like a Faustian bargain. States must surrender substantial control over how they spend a large portion of their budgets in return for sizeable funds from the federal government. Joint funding also makes cutting Medicaid’s budget more difficult. If state leaders cut one dollar from their Medicaid budget, they stand to lose anywhere from $1 to $3.31 of federal matching funds.

Medicaid’s Present

After many years of very low cost growth, the trend in health care costs shifted, and states began to experience higher than expected costs in Medicaid. Costs actually began increasing again in 1999, but few recognized it as a potential problem due to strong economic growth at the time.

It is helpful to remember that today’s cost growth is not out of line with historic trends in Medicaid or health care overall. The tremendous decline in state revenues due to the recession is mostly to blame for the severity of the current crisis. Added to this is a perception problem. Uncharacteristically low health care inflation during the latter part of the 1990s combined with bulging state coffers fostered optimism about Medicaid. The unusual circumstances of the late 1990s made the sudden shift in the fortunes of health care and state budgets in 2001 that much more difficult for state officials to grasp and to counter effectively.

Medicaid is affected by the larger world of health care spending growth, but also has unique features that cause it to differ from overall health care expenditures. Like the private sector, one of the most significant sources of Medicaid cost growth is the retreat from managed care as a cost containment tool. Providers across the board are pushing back on rates that managed care plans pay. Hospital spending now accounts for around 50 percent of health care cost increases. Medical inflation and per capita use of services have increased significantly since 1998, signaling the end of managed care’s containment of both prices and use of health care.

In addition, prescription drug costs are another significant contributor to cost growth in Medicaid. Prescription drug costs have been the fastest-growing portion of the health care dollar, growing at double-digit rates since 1995. An aging populace, the prevalence of chronic diseases that require drug treatment, the boom in new drugs entering the marketplace, and the move toward outpatient drug treatment over expensive and invasive surgical treatments have fueled this growth. Because it covers drug costs for the poor elderly and disabled who are intensive users of prescription drugs, Medicaid has been especially hard hit by prescription drug cost growth.
Two sources of spending growth distinctive to Medicaid are growing enrollment and long-term care costs. With the economic downturn and growing unemployment, Medicaid enrollments increased by 8.6 percent in fiscal year 2002 and are expected to grow by 7.7 percent in fiscal year 2003. Growing enrollment means that states are serving larger numbers of people at higher prices with less money in the bank.

Long-term care costs grew by a seemingly modest 5.3 percent in 2001. However, because Medicaid covers nearly half of the cost for nursing home care and a significant portion of home health care spending, long-term care costs are among the leading drivers of Medicaid spending for state policymakers. Despite Medicaid’s shift to managed care and home and community-based services in the 1990s, a large portion of Medicaid spending for the elderly and disabled—in particular long-term care services—has remained fundamentally unchanged over the years.

In response to these pressures, most states have tried to cut back spending without changing eligibility. Going into the later part of fiscal year 2003, however, the financial situation has caused states to look at steeper cuts to services and eligibility. A survey by the Kaiser Commission on Medicaid and the Uninsured found that states are using a number of strategies to contain costs in Medicaid.

One of the most prevalent cost containment strategies has been prescription drug controls. According to the Kaiser survey, forty-five states are taking steps to reduce prescription drug costs in one or more of the following ways: using prior authorization more intensively (12 states), using or expanding preferred drug lists (9 states), reducing payments (8 states), using supplemental rebates on drugs (5 states), encouraging or mandating use of generics, (2 states), setting limits on the number of prescriptions (5 states), or increasing cost sharing requirements (7 states). In addition to drug controls, states have also frozen or reduced payments to providers (37 states), reduced or eliminated certain benefits such as dental care (25 states), reduced eligibility (27 states), and increased co-payments for enrollees (17 states). Another strategy states have used is to control enrollment growth by eliminating outreach efforts, getting rid of continuous eligibility, reinstating asset test and other policies that were eliminated in order to sign up uninsured kids. States have also used other approaches including disease management (11 states), increased fraud and abuse detection (6 states), as well as increasing federal funds to Medicaid through the Upper Payment Limit (UPL) or “Medicaid loophole” and Disproportionate Share Hospital (DSH) strategies (31 states).

Medicaid’s Future

Given the grave fiscal situation for states, further reductions of payments to providers as well as cuts in benefits and eligibility are inevitable. Some fear that state budget problems will completely undo gains in coverage and increase the number of uninsured. These realities are causing policymakers at both the state and federal levels to take a new look at Medicaid and consider the future direction of the program. At a recent CSG meeting devoted to Medicaid, state leaders across the political spectrum believed that states had all but exhausted their options to deal with Medicaid’s current crisis, both due to budgetary demands and federal oversight. Overwhelmingly, the consensus was that the federal government needs to change Medicaid.

Although officials from different parties see Medicaid’s problems in different ways, generally, state leaders have asked the federal government to either give states greater funding, more flexibility or both. Some state leaders have called on Congress and the Administration to increase the Federal Medical Assistance Percentage (FMAP) as a way to counter the effects of the recession. Many state leaders have also supported a Medicare prescription drug benefit, both 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.

In the midst of these discussions, U.S. Department of Health and Human Services Secretary Tommy Thompson announced the Administration’s new proposal for the Medicaid program. Building on the experience of the Health Insurance Flexibility and Accountability (HIFA) waivers, Secretary Thompson proposed an optional plan for states that would give them flexibility to redesign eligibility and benefits for optional groups without filing a waiver. If states participate in the plan, they 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.

Secretary Thompson provided broad outlines for the new plan and invited the nation’s governors to provide input into the details. The Administration must have Congressional approval before the plan can be implemented, and there are significant reservations about the nature of the Administration’s plan, especially its funding. Critics of the proposal say that it is a block grant and, if implemented, could place state budgets at risk if Congress cuts funds for Medicaid. Supporters of the Administration’s plan say it will...
give states the flexibility they need both to save money and to continue coverage for low-income individuals and families in the most efficient manner.

As changes are debated at the federal level, state leaders are responding to the crisis and their responses provide some indication of the future direction of Medicaid policy in the states. On the prescription drug front, several states, including Florida, Michigan and Oregon, are using preferred drug lists as a way to obtain additional rebates from drug makers and to assure that providers are prescribing the most cost-effective medications. State leaders are also exploring purchasing alliances between states. This option remains untested, but has taken a step forward recently when Gov. Granholm of Michigan and Gov. Douglas of Vermont announced they would participate in a joint purchasing arrangement. Several other states have announced that they would join this group. Five states have also used the new Pharmacy Plus waiver to provide prescription drug assistance to the elderly through Medicaid.24

Another promising avenue are initiatives that interface with employer-sponsored insurance and that leverage funds from multiple sources to enhance coverage to low-income working families. Rhode Island passed legislation that requires commercial insurers to identify members who may also be enrolled in Medicaid. Also, a number of states, including Illinois, Massachusetts, Rhode Island and Tennessee, are using waivers to provide financial assistance to individuals offered employer-sponsored insurance. States help pay the premiums and other cost sharing requirements for employer-sponsored insurance at a much lower cost to the state than if individuals were enrolled in Medicaid. New Mexico’s recent HIFA waiver goes a step further by creating a state-designed health insurance package that will be offered by insurance agents along with private insurance. It is financed through federal, state and employer funds for individuals who are income-eligible.25 Another public/private model is community-based partnerships, like the Muskegon Community Health Project in Michigan, that use funds from employers, individuals and DSH payments to provide coverage for the uninsured.

States have also taken advantage of the increased flexibility available from the Administration to redesign benefits and expand coverage to new populations without spending additional funds. Arizona, Maine, Oregon, Washington, Tennessee and Utah are among the states using this approach.26 Arizona used its HIFA waiver to combine Medicaid and SCHIP funding to provide coverage to more adults. Utah funded a coverage expansion for primary care services to adults under 150 percent of poverty by limiting benefits for certain Medicaid eligibles, folding in a state funded program, and implementing cost sharing requirements. These new waivers have reinvigorated the debate over the tradeoff between deep and narrow coverage (e.g., traditional Medicaid benefits) versus shallow but broader coverage (e.g., SCHIP, employer-sponsored coverage). Medicaid now provides benefits that are more extensive and costly than most employer-sponsored insurance. Some state leaders believe that states should extend coverage to more people by providing less extensive benefits, but this is a contentious issue with advocates for the poor.

Mirroring trends in the private sector, more states are also experimenting with disease management and chronic illness initiatives. Eleven states operated some form of disease management program in 2002, but the number is expected to rise to 21 states in fiscal year 2003.27 Care for chronic illness accounts for roughly 75 percent of health care spending, because chronically ill individuals are heavier users of health care services. Disease management targets health care services to those with chronic illnesses, such as diabetes, heart disease and other conditions. Florida, Mississippi, Virginia and other states have experienced some savings by the use of disease management through ensuring that treatment adheres to accepted guidelines and that patients do not experience expensive, preventable complications.

In addition to disease management, states are experimenting with other approaches derived from the private sector. A few states, including Florida, Iowa and Vermont, have looked at the use of health care savings accounts within Medicaid. Under these arrangements, states place a set amount of funds into an enrollee’s “account” to purchase health care services. Then, beyond a certain amount, individuals are responsible for a portion of the costs. The idea is to help patients be more cost-conscious in their use of health care services.

Other states are borrowing cost sharing approaches from the private sector and adapting them to Medicaid and SCHIP as a means to control cost growth. As Medicaid and SCHIP have expanded to include individuals above 150 percent of the federal poverty level, some analysts argue that cost sharing mechanisms, such as monthly premiums and per visit co-payments, can promote appropriate use of services. Co-payments are generally used to encourage patients to use generics over brand name drugs and to discourage use of the emergency room. Traditionally, cost sharing within Medicaid has been very limited in order to protect low-income individuals from financial risk.

Other consumer-directed approaches address controlling long-term care costs. Several states, including Arkansas, Florida and New Jersey, have operated Cash and Counseling demonstration projects. These programs provide a set amount of funds as well as guidance to elderly and disabled enrollees who purchase and oversee the services they need to stay in their homes.

Finally, states are expanding the use of managed care and other means to coordinate care for special high-use populations. Rhode Island has focused its efforts on moving Supplemental Security Income-eligible children and children in foster care into managed care and has achieved significant savings.28 Other states are looking to administrative reorganization as a way streamline services, not just in Medicaid, but across the board in social services.
Conclusion

As states look toward fiscal year 2004, the outlook for economic growth remains bleak. Combined with continued cost growth in health care, this means that Medicaid is in for another bumpy ride. It remains to be seen what will come of the Administration’s proposal to restructure the Medicaid program and, if it is successful, how many states will opt into the new State Allotment Program. The trend on the state side is a little more clear. Under pressure to balance budgets, states will have to continue to scale back benefits and eligibility within Medicaid to control growth. Yet, even while state leaders are cutting back, they are looking desperately for ways to leverage funds from a variety of sources to maintain coverage. The pressure to find innovative solutions to runaway cost growth is reshaping the face of Medicaid at the state level, pushing states to rethink benefit design and Medicaid’s coordination with other payers and providers. These changes will certainly stay with Medicaid well beyond this economic downturn and provide a picture of what Medicaid may look like many years from now.

Endnotes:
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7Kaiser Commission on Medicaid and the Uninsured, Medicaid: A Primer (August 1999).
8ibid.
9Kaiser Commission on Medicaid and the Uninsured, Medicaid’s Role for Low-Income Medicare Beneficiaries (January 2002).
10Weil, ibid.
11National Association of State Budget Officers, NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal 2003 (March 15, 2002).
12Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Budgets (October 2001).
14As a recent article by Drew Altman and Larry Levitt in the journal Health Affairs lamented, the health care system in the United States has a dismal record of controlling health care spending. During the mid to late 1990s, the rapid expansion of managed care and the competitive insurance market helped to keep costs at their lowest levels of growth in decades. However, cost inflation has returned and the relatively simple economies that managed care used to keep costs down – building networks of providers willing to accept discounted rates and keeping people out of the hospital – are already in use. For more on this issue, see the January 23, 2002 web exclusive available at http://www.healthaffairs.org/WebExclusives/Altman_Web_Excl_012302.htm.
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16Holahan, ibid.
18Levit.et.al., ibid.
19Strunk, et.al., ibid.
20Vernon Smith, Kathy Gifford, et. al., ibid.
22Vernon Smith, Kathy Gifford, et. al, ibid.
23Ibid.
24State of the States, ibid.
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26See the Centers for Medicare and Medicaid Services website for a complete list of current HIFA waivers at www.cms.gov/medicaid/waivers/.
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