

**THE ECONOMIC DOWNTURN AND ITS
IMPACT ON SENIORS**

Testimony

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By

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Mr. Chairman and members of the Aging Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I am also the Co-chair of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. I have previously served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Committee. My testimony reflects my views as an economist and a health policy analyst as well as my experience directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force that I co-chair.

My testimony today discusses the effect of the economic slowdown on the services provided to seniors by the Medicaid program. Health care services are not the only services affected by an economic slowdown but the squeeze on the states from increased Medicaid spending has been particularly severe and thus the potential for service disruption is particularly great.

Recent Medicaid Experience

Medicaid, the Federal-state insurance program covering 44 million low-income people, is experiencing unusual fiscal pressure. Health care spending increases, especially for prescription drugs, have been unusually large at the same time that state revenues have slowed dramatically.

Overall, Medicaid spending grew by 11 percent during FY 2001. This growth represented the fifth year that spending growth in the program has accelerated. Part of the growth reflects recent expansions in eligibility and benefits in addition to increasing reimbursements to providers and increased outreach. A portion of the growth, however, reflects forces that are clearly beyond the state's control; increasing higher prices, increasing enrollments and increasing utilization. The increase in spending on prescription drugs has been especially dramatic - 19 percent in 2001, 22 percent in 2000 and 18 percent in 1999.

The economic decline affects Medicaid spending directly because of the increased numbers of children and adults that become eligible when unemployment increases. But because the elderly represent a disproportionate share of Medicaid spending, any change that affects Medicaid spending can also affect the services that will be available to seniors. The so-called "dual-eligibles", those who are eligible for both Medicare and Medicaid, represent about 16 percent of recipients but account for more than 30 percent of Medicaid spending. The increased rates of spending on prescription drugs and long-term care for seniors are being reported as being particularly burdensome for the states.

In contrast to the growth in Medicaid expenditures, the economic slowdown has been causing states revenues to decline. According to Scott Pattison of the National Association of State Budget Officers, revenues have fallen short of expectations in 39

states while Medicaid spending exceeded budgeted amounts in 37 states. Since most states require a balanced budget, this has put enormous fiscal pressure on the states.

Nor is there an expectation that this fiscal imbalance is about to end any time soon. The Congressional Budget Office expects Medicaid to grow 9.5 percent in FY 2002, less than last year but still a substantial rate of growth. This projection reflects CBO's expectation of high costs for prescription drugs, additional enrollment of children and adults because of higher unemployment and increased use of "upper payment limit" reimbursement. The latter is a billing strategy that allows state to bill Medicaid at rates that exceed the actual Medicaid costs but are below Medicare reimbursements. States are able to receive Federal matching for these higher billings that are never actually made or that are returned to the states after the match is received.

The States' Response

States are responding in a variety of ways to what they have termed their "fiscal crisis." In Oklahoma, stricter income tests are being adopted for pregnant women, children and the elderly, dental services for adults are being reduced, prescription payments are being reduced and a scheduled increase in payments for hospital s and doctors is being indefinitely delayed.

In Indiana, payments to hospitals, nursing homes and pharmacies were cut by 5 percent last fall (although the cut is being challenged in court) and more are being considered. Indiana is also proposing to use a list of "preferred drugs" and to require "prior authorization" for anyone using more than four brand-name drugs per month.

Maine is proposing 5.6 percent cuts in payments to doctors and slightly greater cuts in payments to hospitals and nursing homes.

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As is apparent from these examples, the most common first level of response from the states has been to reduce payments to the various types of providers of services. Several states have also tried to pressure pharmaceutical manufactures to provide deeper discounts than the Medicaid rebates provided for by law since 1991. Thus far, states have been reluctant to reduce benefits or limit eligibility even though Medicaid has substantially expanded coverage to children and their families over the last several years.

The states' have also been aggressively pressuring the Federal government to find ways to slow the growth in Medicaid spending and to assist the states with more financial aid. At the winter meeting of the National Governors Association held in Washington in February, the governors "pleaded with the federal government for financial help." Specifically, they have requested the government to:

- Cover a larger share of Medicaid costs
- Give states the option providing Medicaid coverage to legal immigrants who are not U.S. citizens
- Expand Medicare coverage of home care
- Increase discounts that drug companies must provide to Medicaid
- Freeze or increase reimbursements to "disproportionate share" hospitals
- Eliminate reductions scheduled for reimbursements to public hospitals
- Allow states to charge high co-payments for prescription drugs and other services

The governors have also asked the Congress to look into the 1984 "Hatch-Waxman" law that regulates the relationship between brand-name drugs and their generic competitors to see if the law is contributing to the higher cost of prescription drugs.

What Else States Might Do

The States are obviously finding themselves under extreme pressure in the short term.

Many states are experiencing reduced revenues because of tax reductions introduced in the latter part of the 1990's in addition to the effects of the current economic slowdown. The shortage of revenues is being exacerbated by the expansion of Medicaid to populations not previously covered and by the unusually rapid rate of growth in health care spending being experienced throughout the country.

The growth in health care spending has occurred in all area of spending but has been particularly notable in the area of prescription drugs. Much of this increase represents the use of newer, more powerful and more expensive prescription drugs rather than traditional inflation in the prices of existing drugs. Although prescription drug spending generally represents only 10 percent of total spending in health care, it has been a more important item for the states because of the lack of prescription drug coverage under Medicare and the importance of the dual-eligible population for Medicare spending.

The easiest ways for states to reduce Medicaid spending in the short run is to reduce payments to providers, which is the strategy that many states are in the process of undertaking. The problem is that Medicaid already pays most providers less than any other payer and further reductions risk reductions in access or quality, although the risk is probably not too great in the short run.

The challenge is for states to find other things to reduce Medicaid spending. One other way to reduce Medicaid spending is to reduce the quantity of services provided to Medicaid recipients. Unfortunately, for the states, the easiest reductions have already occurred. During the 1990's states rapidly moved large numbers of their acute care Medicaid populations into managed care plans that were able to introduce better control over the volume of services and in some cases, substantially lower the reliance on emergency room visits as a source of primary care.

States have been far less successful in finding innovative, cost-effective strategies for dealing with long-term care, an area of particular concern for seniors. Most of the home and community-based care has not been shown to reduce spending because of difficulties in targeting populations who otherwise would truly be likely to go to nursing homes although home and community-based care is far more popular with seniors than institutional care. Arizona is one of the few states that has actively tried to bring managed care strategies to its long term care population and may have programs that would provide some relief to other states. This committee, in particular, should be concerned about the use of repeated reimbursement reductions to nursing homes, given the various reports about staffing and quality issues raised by this committee in the past.

The other area of most concern to seniors is prescription drug coverage. States need to be careful about how they attempt to lower spending in this area. Too many times in the

past, states have attempted to introduce "simple" strategies to reduce spending, which may have actually increased spending. One state that had introduced absolute limits on the use of branded name drugs, including the use of anti-psychotic drugs, found it was experiencing an increase in the rates of institutionalization of schizophrenics, hardly a money-saving strategy. Another state that recently required the use of generics whenever generics existed only to find that brand-name products that had recently come off patent are sometimes cheaper than generics.

Focusing more attention on the highest cost users has produced some cost savings although these types of programs take time to introduce and therefore aren't good "quick-fixes". The Combined Benefits Fund of the United Mine Workers of America, which provides health and retirement benefits for their retirees and spouses, has introduced a program which combines the use of generic substitution, preferred products, geriatric case management and disease management for several high cost illnesses, like congestive heart failure and diabetes. Although the full program has only been in place for a relatively short period, it appears to be producing some significant savings while improving or at least not diminishing the care being provided to a particularly frail and sick population.

Several states have talked about introducing disease management programs for high cost illnesses in order to reduce the number of emergency admissions and hospitalizations that

can occur when patients fail to take medicines properly or otherwise fall out of compliance with their medical regimen.

Developing protocols to guide the use of the newest and most expensive therapeutics rather than placing arbitrary limits on their use is another preferred but more time-consuming strategy. In general, both the pharmaceutical industry and various patient-advocate groups have resisted attempts at any type of prior authorization or formulary use in Medicaid but the use of clinically developed protocols could improve care as well as potentially save money.

Finally the use of innovative strategies to encourage middle class people to insure themselves for long-term care might reduce the burden on the states in the future. One such strategy involves the use of “partnership” plans that encourage people to insure themselves by providing partial asset protection during Medicaid “spend-down”, that is an amount equal to the value of the long term care insurance is disregarded during spend-down asset calculations. A few states experimented with such programs in the 1990’s but much more could be done.

What the Federal government should watch out for is the use of creative financing strategies by the states that unilaterally increase the amount of Federal matching dollars, without prior agreement by the Federal government. I regard the “upper payment limit’

billings as falling in this category along with the use of voluntary donations and provider tax strategies used by the states in the early 1990's.

Prescription Drug Coverage Under Medicare

States would obviously experience substantial savings in Medicaid if Medicare were to cover outpatient prescription drugs. Although, I believe it is important to pass a reformed Medicare program as soon as possible and that a reformed Medicare benefit package should include outpatient prescription drug coverage, I also believe that just adding prescription drug coverage to the Medicare program that now exists is not the place to start the reform process.

The most important reason not to start the reform process by adding prescription drug coverage is that there are a series of problems that need to be addressed in order to modernize Medicare: inadequate and inequitable benefits, financial solvency, excessive administrative complexity and a complicated bureaucracy.

Part of the motivation for Medicare reform has traditionally been financial. Concern about the solvency of the part A Trust Fund helped drive the passage of the Balanced Budget Act in 1997. Part A, which funds the cost of inpatient care, Medicare's coverage of nursing homes and the first 100 days of home care, is primarily funded by payroll

taxes. The changing demographics, that is, the retirement of the 78 million baby-boomers between the years 2010 and 2030 followed by the baby-bust generation, means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline. The strong economy of the last decade combined with the slow growth in Medicare expenditures for FY 1998-2000 has provided more years of solvency than was initially projected but even so, Part A is expected to face cash flow deficits as soon as 2016. The outlook may be gloomier when the Social Security Trustees report on the status of the Trust Fund later this month.

As important as issues of Part A solvency are, however, the primary focus on Part A as a reflection of Medicare's fiscal health has been unhelpful and misleading. Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors, is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially faster than both Part A and than the economy as a whole. This means that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling Part B expenditures will mean fewer dollars available to support other government programs.

However, the reason to reform Medicare is far more than financial. Traditional Medicare is modeled after Blue Cross/Blue Shield plans of the 1960's. Since then, there have been

major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made as well as other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the population.

Much attention has been given to the outdated benefit package. Unlike almost any other health plan that would be purchased today, Medicaid provides almost no outpatient prescription drug coverage and no protection against very large medical bills. Because of the limited nature of the benefit package, most seniors have supplemental traditional Medicare although some have opted-out of traditional Medicare by choosing Medicare+Choice.

The use of Medicare combined with supplemental insurance has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with some plans exceeding \$3000 in annual premiums. The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far

more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. These large variations in spending mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles to people living in higher medical cost states and states with aggressive practice styles. The Congress and the public is aware of these differences because of the differences in premiums paid to Medicare+Choice plans but seem unaware that the differences in spending in traditional Medicare is now even greater than the variations in Medicare+Choice premiums.

Finally, the administrative complexities of Medicare, the difficulties that CMS and the contractors face administering Medicare and especially the frustrations that are being experienced by the providers providing care to seniors are issues that have been raised repeatedly during the last year. Although these are not new issues, the frustration being felt by providers has increased substantially. Physicians, in particular, have become increasingly vocal, as was evidenced in a number of the hearings that were held last year. Among the many complaints that have been raised--uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment seem to be at the top of the lists. A GAO report recently released entitled "Medicare Provider Communications Can Be Improved" verified the validity of those complaints.

In sum, as much as adding a prescription drug benefit would help the states and as important as it is to seniors to have prescription drug coverage, introducing an expensive new benefit, that would substantially increase spending in a program that is already financially fragile relative to its future needs, without addressing these other issues of reform, is bad idea.