Statement of Barbara Lyons, Ph.D.

Thank you for the opportunity to offer testimony this morning on the critical issue of how the economic downturn may affect Medicaid's role for seniors. I am Barbara Lyons, Deputy Director of the Kaiser Commission on Medicaid and the Uninsured and Vice President of the Henry J. Kaiser Family Foundation. The national bi-partisan commission serves as a policy institute and forum for analyzing health care coverage and access for low-income populations. Medicaid is the nation's major public program for financing health and long-term care coverage to 44 million low-income Americans, including over 4 million seniors. Low-income seniors depend on Medicaid for help with medications, meeting Medicare's financial obligations, and paying for long-term care. The downturn in the economy, coupled with increased pressure on state budgets, place Medicaid's protections at risk for low-income populations. My testimony today will focus on the role that Medicaid plays for seniors, the likely impact of increased pressure on state budgets and rising health care costs, and the challenges to Medicaid's protections for seniors in the current fiscal environment.

Medicaids Role for Low-Income Seniors

Today, over four in ten (44%) seniors in America have an income below twice the federal poverty level—or $17,720 for an individual and $23,880 for a couple in 2002 (Figure 1). These low-income elderly people depend on Social Security for the bulk of their income (over 80 percent, on average) and are especially vulnerable to rising health care costs. Poverty rates vary greatly among different segments of the elderly population. Women, those ages 85 and older, and those living in rural areas are more likely than others to have low incomes. Low-income seniors tend to have more health problems than do their higher income counterparts, suggesting that those least able to afford health care services are often most in need of them.

Medicaid plays an essential role for 4.2 million low-income elderly Americans. Although Medicare provides basic protection against hospital and physician costs, Medicare's benefits gaps and financial obligations can impose significant financial burdens on low-income beneficiaries, who are less likely than higher income beneficiaries to have private coverage to supplement Medicare. Medicaid, a means-tested entitlement program funded by federal and state governments, fills in Medicare's gaps for 17 percent of Medicare's elderly and disabled beneficiaries and over half of beneficiaries living in poverty (Figure 2).

The scope of coverage available from Medicaid for elderly people varies by income and across states (Figure 3). The poorest elderly, including those who qualify for the Supplemental Security Income (SSI) program and, in most states, those who have exhausted their personal resources paying for health and long-term care, receive assistance with Medicare's financial requirements (premiums and cost-sharing) and the full range of Medicaid benefits. These beneficiaries, known as dual eligibles, rely on Medicaid primarily for wrap-around benefits not covered by Medicare, such as prescription drugs and long-term care.

The dual eligible group includes some elderly people who "spend-down" to Medicaid eligibility levels. These beneficiaries qualify for Medicaid in some states due to catastrophic nursing home bills incurred due to chronic illnesses, or dementias such as Alzheimer's disease. Current law penalizes those who transfer assets up to three years (and in some cases, five years) before

application for Medicaid in order to qualify for nursing home coverage. Most elderly people live on limited incomes and few can afford the high cost of long-term care. Medicaid is the safety net because no other practical options exist to meet these seniors long-term care needs.

States vary in their full Medicaid coverage of the low-income elderly. For the non-institutionalized population, some states cover the elderly at eligibility levels lower than SSI (referred to as "209b" states), some to the SSI level, and some to 100 percent of poverty. Similarly, states vary in their eligibility standards for the institutionalized elderly; 33 states cover only those with incomes up to 300 percent of the SSI payment standard; 34 states and DC cover the elderly through medically needy "spend-down" programs. As a result of these choices and underlying rates of poverty, Medicaid's coverage of the low-income elderly varies across states, ranging from 4 percent in New Hampshire to 36 percent in Mississippi (Figure 4).

While most elderly people who participate in Medicaid receive full Medicaid benefits, other low-income beneficiaries may receive assistance primarily limited to Medicare premiums ($54/month in 2002) through four related programs, often referred to as "buy-in programs" or "Medicare Savings programs". Medicaid's financial assistance makes Medicare's benefits meaningful for low-income seniors by providing protection from burdensome out-of-pocket costs that result from use of physician and hospital care.

Although the elderly comprise a relatively small share of Medicaid beneficiaries (10%), they account for over a quarter (24.5%) of Medicaid spending, largely due to their intensive use of acute care services and the costliness of long-term care in institutional settings (Figure 5). CBO estimates that in 2001, the average annual per capita cost for an elderly beneficiary was $12,322, compared to $11,238 per disabled beneficiary and $1,447 for a child (Figure 6). Nearly three quarters (73%) of Medicaid spending on the elderly is devoted to long-term care, primarily nursing home care (Figure 7). Medicaid spending on acute care is limited to filling in Medicare cost-sharing for physician and hospital care and providing coverage of prescription drugs, which Medicare does not cover.

States that choose to participate in Medicaid are required to provide Medicaid to the lowest income seniors, generally those eligible for SSI and to help poor seniors with Medicare premiums and cost-sharing. Nationally, 44 percent of seniors who are covered by Medicaid fall into these mandatory eligibility categories (Figure 8). However, most seniors (56%) are covered through "optional" categories because states have chosen to provide Medicaid to those impoverished by high medical and long-term care expenses and other low-income seniors who do not qualify for SSI. The vast majority (83%) of Medicaid spending on seniors is also not required under federal law. This spending is attributable to decisions states have made to provide "optional" services to both optional and mandatory eligibility groups. Optional services include some key benefits under Medicaid, such as prescription drugs and home and community-based services. Many optional services are, in fact, medically necessary and contribute to better, more appropriate, and cost-effective care.

Medicaid coverage to supplement Medicare substantially improves access to care for low-income seniors. Low-income Medicare beneficiaries with Medicaid are much more likely than those with no supplemental coverage to have a regular source of care and to obtain care in a timely manner (Figure 9). Medicare beneficiaries with Medicaid also have lower out-of pocket costs, spending four to five times less as a share of their income on health care than the average

low-income Medicare beneficiary (Figure 10). Because most seniors covered by Medicaid receive assistance with the cost of prescription drugs, they are generally protected from the high costs of medications.

Long-term care comprises the largest share (40% in FY 2000) of Medicaid expenditures. Medicaid finances two long-term care benefits for low-income seniors: 1) nursing home care; and 2) home- and community-based services. Providing adequate services to the long-term care population is challenging. Seniors in need of long-term care are often extremely frail and vulnerable and without support in the community. Of the 1.3 million elderly in nursing homes, half are over age 85 and more than 80 percent are severely impaired (requiring assistance with 3 or more ADLs). Medicaid tries to promote quality care in nursing homes by tying payment to quality standards, although concerns remain over issues related to monitoring nursing home quality and enforcement of quality standards.

Medicaid is the only public program that covers ongoing nursing home care, but coverage is available only after people exhaust virtually all of their own resources. Medicare pays for some long-term care of limited duration, but Medicaid pays the largest share of public expenditures for long-term care. Medicaid finances care for over two-thirds of the nation's 1.5 million nursing home residents and pays for nearly half of nursing home costs (Figure 11). The large role that Medicaid plays in paying for nursing home care results because nursing home care is expensive (about $55,000 per year on average) and beyond the financial means of most elderly Americans.

In addition to those in nursing homes, a comparable number of elderly persons (1.5 million) have substantial long-term care needs and receive care in the community. They are disproportionately low-income, very old, and in fair or poor health and may or may not receive Medicaid assistance with long-term care needs. States vary substantially in the availability and scope of community-based services. Although states have increased the availability of Medicaid home and community-based alternatives (nearly 400,000 seniors receive assistance through home and community based waivers), access remains limited and fiscal concerns have constrained the broader development of these efforts.

State Fiscal Pressure and Medicaid

Revenue shortfalls, combined with increasing Medicaid costs, are creating significant budget stresses in many states. Spending on services, especially prescription drugs and nursing home care, as well as "buy-in" subsidies for the elderly, are all factors in Medicaid spending growth. Federal law gives states broad discretion in adjusting Medicaid expenditures, however, in deciding whether to reduce state Medicaid spending on the elderly, states must consider not only the impact on beneficiaries, but also the loss of federal matching funds to their health care economies.

Medicaid's role in financing health and long-term care assistance to low-income seniors and other vulnerable populations is an essential part of the health financing system in every state. Medicaid is the largest source of federal financial assistance to states, accounting for 42 percent of all federal grant-in-aid. The financial assistance that states receive as matching payments from the federal government, along with their own expenditures, makes Medicaid a dominant part of state budgets.

After nearly a decade of strong economic growth, states' fiscal conditions began to deteriorate at the end of 2000. During the mid-to-late 1990s, most states reaped the benefits of the nation's

sustained economic expansion and were able to shore up their budget reserves. State budget reserves grew from 5.8 percent of expenditures in FY 1995 to 10.4 percent in FY 2000 (Figure 12). In the second half of calendar year 2000, however, states began to see their tax collections fall as a result of a slowing economy. As a result many states had to dip deeply in their year-end balances to cope with budget pressures. The outlook for this year is even bleaker, primarily because state revenue growth has slowed dramatically. In the third quarter of 2001, state revenues actually declined by 3.1 percent from 2000 levels, the first such decline since the end of the last recession of the early 1990s. Preliminary numbers showed that state revenues declined again in the fourth quarter of 2001. As of January 2002, the National Association of State Budget Officers reported that 40 states projected an aggregate shortfall of approximately $40 billion for fiscal year 2002.

Although the major factor behind many states' budget problems is the decline in revenue growth, a number of states are finding that their spending, particularly their Medicaid spending, is exceeding budgeted levels. During the past year, many state policymakers have expressed concern about the rate of growth in Medicaid spending. After a four-year lull in the mid-to-late 1990s when Medicaid expenditures grew far below historical averages due to declining enrollment, managed care savings, and low health care inflation, Medicaid spending has begun to rise at a more rapid rate. In FY 2000, Medicaid spending grew 9 percent and in FY 2001 it grew an estimated 11 percent. Over the next several years, the Congressional Budget Office anticipates that Medicaid will grow at an annual rate of 8 to 9 percent (Figure 13).

Of particular concern to states is that future Medicaid spending growth is projected to outpace relatively weak revenue growth, causing Medicaid to consume a larger share of state budgets over time. On average, states spend 15 percent of their general fund expenditures on Medicaid, making it the second largest budget item (after elementary and secondary education, which accounts for 36 percent of spending) (Figure 14). Since the mid-1990s, Medicaid has remained relatively constant as a share of state budgets, but as of last summer, states were projecting that their revenues would grow by only 2.4 percent during fiscal year 2002 even as their Medicaid spending was slated to grow by 8.7 percent (Figure 15). Given these revenue and spending projections and a growing low-income population from the declining economy, it seems almost certain that Medicaid is slated again to grow as a share of state spending.

Factors Contributing to the Rise in Medicaid Spending

Not surprisingly, the elderly accounted for a significant portion of the growth in Medicaid spending. According to a Kaiser Commission analysis of federal Medicaid spending projections by the Congressional Budget Office, the increased cost of caring for the elderly was the second largest factor (following the disabled who also have significant long-term care needs) behind the $12.4 billion increase in federal Medicaid spending between 2000 and 2001 (Figure 16). Among the elderly, all of this growth was attributable to an increase in the per capita cost of serving this population and not an increase in the number of seniors covered.

The trends in Medicaid expenditures in recent years have tracked to a large degree the trends in private sector health spending, with health care inflation explaining much of the growth in spending on publicly financed health programs, as well as employer-based coverage. Health-care costs, particularly those for prescription drugs, have begun to rise more rapidly than in past years: in 2000, national health expenditures for prescription drugs increased over 17 percent

from the previous year, and hospital and physician services increased 5 and 6 percent, respectively (Figure 17). These rising costs are reflected in increases in employer-based health insurance premiums, which rose 11 percent between 2000 and 2001.

Cost increases in the private market put pressure on Medicaid programs to keep pace as a major purchaser of care. In order to maintain access to care for their beneficiaries, Medicaid programs are being pushed to raise payment rates for health plans and providers and pay for the escalating cost of prescription drugs. In a survey, conducted by Health Management Associates last year for the Kaiser Commission, state Medicaid officials reported that the top reasons for Medicaid expenditure growth in FY2001 were pharmacy costs (48 states); provider rate increases (31 states); enrollment increases from eligibility expansions and growth of the disabled population (27 states); and increased costs for long-term care (24 states) (Figure 18). Many states indicated that these cost increases were due to the need to increase provider rates in a competitive labor market to assure participation and maintain access to care. Evolving patterns of health care utilization—with greater reliance on prescription drugs and home and community-based services for long-term care—mean these cost pressures are likely to continue.

Virtually all public and private payors for health care are grappling with increased expenditures for prescription drugs. Data from the Center for Medicare and Medicaid Services (CMS) show that Medicaid spending for outpatient prescription drugs increased by more than 90 percent in Nevada, New York, North Carolina, Oregon, South Carolina, Vermont, and Washington from 1997 to 2000. Overall, Medicaid spending for outpatient prescription drugs increased by an average of 19 percent between 1998 and 2000, compared to 9 percent for total expenditures (Figure 19). While states are not required to include prescription drugs in their Medicaid benefit packages, all do. Medicaid is an important source of drug coverage for low-income seniors who accounted for 25 percent of Medicaid prescription drug spending in 1998 (Figure 20).

Long-term care services are a particularly important—and expensive—component of Medicaid. Typical private health plans do not cover these services, leaving Medicaid as the primary source of coverage for patients who have exhausted their ability to pay for these services out-of-pocket. Medicaid long-term care spending increased by 7.2% per year between 1998 and 2000. Medicaid spending for home care services—including home health services, home and community-based services (including waivers) and personal care services—grew by 11.7% per year. These services have increased at double digit rates for several years, and the rate of growth may reflect the pressure to increase nursing home quality by increasing staffing and increasing wages in response to labor shortages, but in the case of nursing home services may also reflect more widespread use of upper payment limit (UPL) programs using higher payments to certain nursing homes to draw down additional federal funds. However, continued pressure to increase nursing home expenditures is likely in view of ongoing quality concerns.

State Responses to Rising Medicaid Expenditures During an Economic Downturn

Some states are trying to hold the line and not reduce funding this year, but others have already initiated budget-reduction actions for fiscal year 2002. States are considering, and some have implemented, reductions in provider payments, eligibility, and /or benefits; capping enrollment in the State Children's Health Insurance program; or putting planned expansions on hold. Others are planning to use waiver authority (including, the new Health Insurance Flexibility and Accountability Demonstration Initiative, or HIFA) to expand coverage under Medicaid and, in

some cases, to address budget problems. Although waivers have been used by states to gain additional flexibility over eligibility and benefits, current federal policy requires that they be "budget neutral" and, therefore, do not provide additional federal funds.

The tightening budget situation, coupled with the increased rate of growth in Medicaid spending, has prompted states to explore strategies for controlling cost growth. Because states make different decisions about what populations to cover, what benefits to provide, and what amounts to pay for services, the scope and cost of the program and the nature of the responses to fiscal pressure will continue to vary widely across the states. Historically, states have looked to cutting provider payments to hospitals and nursing homes as a first step in constraining spending and most are likely to turn to curbing provider payments again with implications for access and quality.

In addition, most states are focusing significant attention on controlling the rise in prescription drug spending, which has been growing at double-digit rates and accounts for 17 percent of the increase in total Medicaid expenditures during the past two years. A number of states have imposed new prior authorization requirements, while others have limited the number of prescriptions that beneficiaries can have in any given month. Some options (e.g. utilization review, generic substitution) have the potential to curb spending growth while also improving or maintaining quality of care. Other strategies, such as increased cost-sharing or imposition of caps, may in fact place an undue burden on low-income elderly beneficiaries who often require multiple prescriptions to manage health conditions.

Strengthening Medicaid's Future in a Strained Fiscal Environment

The current combination of forces affecting Medicaid, including increasing expenditures and slow revenue growth, could make it increasingly difficult for states to maintain current coverage or take on new responsibilities for improving coverage and quality of care. As we look toward the future, demographic trends related to the aging of the population and rising health care costs will increase the pressure on the Medicaid program to meet the substantial health and long-term care needs of vulnerable populations.

Consideration of alternatives to assure adequate coverage and financing is likely to be essential to Medicaid's future success in serving as this nation's safety net program. Proposals for the federal government to pick up a larger share of the cost of operating Medicaid during difficult economic times or provide some fiscal relief to states and the federal government from the rising cost of providing prescription drugs through Medicaid by strengthening the rebate program would help to maintain coverage in the short-term.

Broader proposals with long-term implications focus on shifting from the states to the federal government more responsibility for two acute care benefits for low-income seniors that many states view as more properly Medicare's responsibility: 1) coverage of prescription drugs and 2) subsidies for premiums and cost-sharing. Given the revenue shortfalls that many states are experiencing, one option for Congress to consider is picking up the federal share of state expenditures for the elderly for either or both of these responsibilities. This would provide needed fiscal relief to states and realign federal-state responsibilities for the long-term.

Medicaid's role in coverage of elderly populations will be shaped by future Medicare policy. Most notably, enactment of a prescription-drug benefit under Medicare could have a substantial impact on state Medicaid spending if Medicare takes over some responsibility for prescription

drug coverage for low-income Medicare beneficiaries. Alternatively, if no action is taken on this issue, more pressure may be placed on Medicaid to assist low-income elderly people. Among the ten million Medicare beneficiaries without prescription drug coverage, 5.8 million have incomes below 200% of poverty. These beneficiaries are at risk for substantially higher out-of-pocket spending and are much less likely to have prescriptions filled. Expanding prescription drug coverage to elderly people who do not currently qualify for Medicaid without substantial new federal and state funds raises concerns over how this financing would be accomplished.

Medicaid is the single largest payor for long-term care services and has an important impact on quality. Low payments to nursing homes have historically limited access to care for Medicaid beneficiaries and long-standing concerns about the quality of care in nursing homes persist. As the GAO testified before you earlier this month, abuse of nursing home residents still occurs at unacceptable levels in facilities receiving Medicaid subsidies. As the major program financing nursing home care, Medicaid needs to take a stronger role in assuring that the care delivered is not substandard and assure that payment levels are appropriate for care required because the population needing nursing home is frail and vulnerable and the numbers of Americans needing these services will continue to grow.

The aging of our population will put additional pressure on Medicaid's role as the primary source of long-term care coverage. In the next 30 years, the elderly population age 85 and older—those at greatest risk of needing long-term care—is expected to triple. In the absence of long-term care reform to replace Medicaid's role in financing home and institutional care, Medicaid responsibility for financing and assuring quality of long-term care is likely to grow.

Conclusion

As a safety net for the most vulnerable and needy Americans, Medicaid has been charged with the task of serving low-income people whose health and social needs are extremely complex. For low-income seniors, Medicaid has provided essential protection, by filling gaps in acute care coverage, particularly for prescription drugs, and being the major support for long-term care services in the community and in institutions.

The challenge for the future is how to maintain and build on these achievements in light of the downturn in the economy. State budgetary problems, coupled with the pressure to restrain health care spending, portend difficult times ahead. Medicaid is an essential source of health coverage for low-income families, as well as health and long-term care financing for the elderly and people with disabilities. The resource needs of these disparate groups, to some extent, compete with each other for state dollars. Given Medicaid's role as our health and long-term care safety net, it is essential that attempts to constrain costs not compromise the care available to the poorest and sickest people in our nation.

I commend the Committee for its efforts to highlight the important role that Medicaid plays for seniors and examining ways to strengthen, rather than erode, the important protections provided by Medicaid in tough economic times. I look forward to working with the Committee to meet the challenge of assuring access to health and long-term care for low-income seniors today and in the future.