Testimony of

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Mr. Chairman and Members of the Special Committee on Aging:

I am Vernon Smith, an economist, former Medicaid director in Michigan and now a Principal with Health Management Associates in Lansing, Michigan. It has been an important part of my work over the past several years to track Medicaid trends. I am very pleased to be here today to discuss with you critically important emerging issues relating to the economic downturn and its affects on state Medicaid programs and health care services for seniors.

Over the past decade, Medicaid has undergone tremendous change and growth. As the program has changed and grown, it has become increasingly important as the source of health coverage for the low-income populations it serves. My testimony is intended to describe how the economic downturn is affecting state revenues and in turn, threatening Medicaid and the health care services it provides for seniors.

Medicaid now provides coverage for 44 million Americans, including 32 million low-income working families and their children, and 12 million persons who are elderly or disabled, including about 7 million persons who also are on Medicare.

For low-income seniors and others on Medicare, it is *Medicaid* that pays for the Medicare premiums, coinsurance and deductibles, and for services that Medicare does not cover. Notably, these services are prescription drugs and long-term care. Medicaid's role in supporting persons on Medicare has grown to the point that over one-third of Medicaid spending now is for persons also on Medicare.[1]

Medicaid is the primary source of financing for long term care in the U.S., including coverage for nursing home care and care in home and community settings.

Once regarded as health coverage primarily for persons on welfare, Medicaid is now much more than that. If fact, most persons on Medicaid now are not receiving cash assistance from welfare.[2]

In recent years, much focus has been on the growth in Medicaid enrollment and costs, and for good reason. From 1990 to 2002, the number of persons enrolled in Medicaid soared from about 28 million to 44 million. Over this same period, total program expenditures more than tripled from $72 billion to over $250 billion (according to the Congressional Budget Office, January 2002 Baseline.)[3]

As a result, Medicaid is now largest single health program in America. Medicaid is now even larger than Medicare. In FY2002, Medicaid will serve 44 million persons, and Medicare will serve 40 million persons.

In FY2002, Medicaid total expenditures (net of co-payments, premiums and third party collections) will be $250.4 million, and Medicare expenditures (net of co-payments, premiums and third party collections) will be $227.2 billion.[4]

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[1] The most recent available data show 35% of Medicaid spending supplements Medicare coverage in 1997. Source: Medicare Chart Book, Second Edition. The Henry J. Kaiser Family Foundation. Fall 2001.

[2] Eileen Ellis and Vernon Smith, *Medicaid Enrollment Trends: June 1997 to December 2000*, Kaiser Commission on Medicaid and the Uninsured (forthcoming). Based on a national survey of all states, 37% of Medicaid enrollees were receiving cash welfare assistance in December 2000, and 63% were not. Of 17 states reporting these data for December 2000, the proportion on welfare was less than 20% in two states.

[3] FY2002 data for Medicaid and Medicare enrollment and expenditures presented here are from Congressional Budget Office, January 2002 Baseline. Expenditures for both Medicaid and Medicare are net of receipts, third party collections and premiums.

[4] Congressional Budget Office, January 2002 Baseline.

Table 1:
Medicare and Medicaid Beneficiaries and Expenditures, Federal Fiscal Years
2001, 2002 and 2003

Program	Fiscal Year 2001	Fiscal Year 2002	Fiscal Year 2003*
Number of Beneficiaries:			
Medicaid	42.7 million	44.0 million	43.7 million
Medicare	39.5 million	40.0 million	40.0 million
Expenditures:			
Medicaid-Federal Only	$129.7 billion	$142.7 billion	$152.0 billion
Medicaid-State	$ 97.8 billion	$107.7 billion	$114.7 billion
Medicaid-Total Expenditures	$227.5 billion	$250.4 billion	$266.7 billion
Medicare Expenditures	$217.4 billion	$227.2 billion	$238.9 billion

**Medicaid enrollment and expenditures for FY2003 do not include Transitional Medical Assistance, which is included in the re-authorization of Temporary Assistance to Needy Families (TANF).*
Source: Congressional Budget Office, January 2002 Baseline. For each program the definition of enrollment is an unduplicated count of persons enrolled for any length of time during the federal fiscal year. For each program the definition of expenditures is total spending less collections for third party payments, premiums and coinsurance. Medicaid-State and Total Expenditures are estimated by Health Management Associates assuming an average federal matching rate of 57% and includes local funds in some states. Medicare enrollment is from the CBO April 2001 Baseline.

This is a comparison that is rarely seen, because of the way the programs are administered and budgeted. On the one hand, *Medicare* is a national program administered by the federal government, and costs paid by Medicare are in the federal budget. On the other hand, *Medicaid* is a federal-state program, defined and administered by each state, financed with federal matching funds and state (and in some states, local) funds, and the costs paid

by Medicaid are in state budgets. Only the federal share of Medicaid is in the federal budget. In federal FY2002, the federal share of Medicaid is projected to be $142.7 billion, about 57% of the total.

For FY2002 the states' share of Medicaid is projected to be $107.7 billion, or about 43% of the total.

For states, the important comparison is between the growth in state revenues and the growth in the state cost of Medicaid. Medicaid spending since 1988 has increased by an average of 12% per year. State revenues grew only half as fast, on average about 6%. (Figure 1)

As a result, Medicaid has grown as a share of state budgets, and has become one of the largest of all state programs. In 1985, for example, Medicaid expenditures were 8% of overall state budgets, on average, according to the National Association of State Budget Officers. By 1995, total Medicaid expenditures accounted for 20% of the average state's budget.[5]

From 1995 to 2000, a number of trends worked together to stabilize the Medicaid share of state budgets. On the expenditure side, Medicaid spending increases were at historic lows, due in part to the effects of welfare reform (which contributed to three years—1996, 1997 and 1998—when Medicaid enrollment actually dropped) and managed care (which contributed to lower rates of growth in overall health care costs). In a fortuitous coincidence, over this same period state economies and tax collections were robust. As a result, Medicaid remained at about the same 20% share of overall state spending over this five-year period.

That situation changed quickly in 2001, as Medicaid cost growth has re-emerged as a significant issue. Just about a year ago, states across the country began to report that Medicaid spending was outpacing legislative authorizations for fiscal year 2001. Altogether, a total of 37 states experienced a budget shortfall that required supplemental funding for Medicaid for state fiscal year 2001.[6]

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[5] Another measure is Medicaid state general fund spending as a share of total state general fund spending: from 1987 to 1995 Medicaid general fund spending alone grew from 8% to 15% of state general fund spending. Calculated from data provided by National Association of State Budget Officers, State Expenditure Reports.

[6] Vernon Smith and Eileen Ellis, *Medicaid Budgets Under Stress, Survey Findings for State Fiscal Years 2000, 2001 and 2002*, Kaiser Commission on Medicaid and the Uninsured, October 2001. Publication # 4020.

State Medicaid officials have indicated that Medicaid costs were being driven by four key factors in 2001. The most significant was the increasing costs of prescription drugs, and a second key factor was the increasing costs of long-term care. Other key factors included provider payment increases and a surge in program enrollment.[7]

These forces continue to drive Medicaid spending in FY2002, and Medicaid spending growth will again exceed the growth of other state programs. For FY2002 state legislative initial appropriations provided on the average increases of 3.0 percent to 3.7 percent for primary state programs such as K-12 education, higher education and corrections. For Medicaid, FY 2002 initial legislative appropriations authorized spending increases that averaged 8.8 percent.[8] These growth rates will change based on mid-year budget cuts in these programs, but for Medicaid the growth rate is expected to increase, not decrease. State officials have indicated that Medicaid spending will increase by about 11 percent in 2002, and supplemental appropriations are likely in at least as many states as in 2001.[9]

Table 2:
Growth in Initial State General Fund Appropriations for Selected Programs, FY2002

State Program	Percentage change in State General Fund Appropriations FY2001 to FY2002
K-12 Education	3.7%
Higher Education	3.6%
Corrections	3.0%
Medicaid	8.8%

Source: National Conference of State Legislatures, 2001.

The current growth in Medicaid costs would not be the very serious problem that it is if state revenues—that provide the state share of Medicaid costs—were increasing at a similar rate. Unfortunately, that is not the case. In fact, state general fund revenue growth has flattened or decreased in most states. According to an analysis prepared for the National Governors Association in February 2002 by Mark Zandi of Economy.com, state revenues on average

[7] Smith and Ellis, Medicaid Budgets Under Stress, 2001.
[8] National Conference of State Legislatures, 2001.
[9] National Association of State Budget Officers, 2002.

will decrease by 3.8% in FY2002 compared to the prior year, and net borrowing by state and local governments is at a record level.[10]

Further current evidence of the decline in state revenues is in an analysis by Don Boyd of The Nelson A. Rockefeller Institute of Government. It shows state tax revenue declined an average of 2.7% in the most recent quarter (October-December 2001), compared to the same quarter a year before, the second quarter in a row of decline. In presenting his results to the New York State Revenue Forecasting Conference on March 6, 2002 he described the continuing decline in state tax collections in January and February 2002 as "devastating." Presenting the most recent data available (and therefore still preliminary), Boyd indicated that 24 of the 30 states with complete reporting for both December 2001 and January 2002 had a year-over-year decline in estimated payments of income tax, with a median decline of 15%, and six states had a decline of more than 30%.[11]

Slowing revenue growth was generally anticipated by states when appropriations were made for FY 2002, but not to the extent that actually occurred. The revenue drop has created overall budget shortfalls in almost every state. As of January 2002 a total of 40 states reported overall state budget shortfalls. The total of these shortfalls amounted to $40 billion.[12] With constitutional requirements to balance their budgets, most states have been forced to initiate broad budget reduction actions in FY 2002.

Nor is the outlook good. As economists forecast a slowly recovering economy, the same cannot necessarily be said for state revenues. After a drop of almost 4% in FY2002, revenues would need to increase by 4% or so in FY2003 just to match revenues of FY2001. According to Don Boyd, as states look at their own situations "they will be raising their economic forecasts and lowering their revenue forecasts."[13]

Because Medicaid is such a large share of state budgets, it is virtually impossible for states to slow the growth of overall state expenditures without including Medicaid in the group of programs to be cut. As a major state program Medicaid is expected to do its share. As a result, almost every state

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[10] Mark Zandi, *The Outlook for State Tax Revenues*, Economy.com, February 2002.
[11] Don Boyd, *State Tax Revenue Trends Around the Nation*, PowerPoint Presentation to New York State Consensus Forecasting Conference, Albany, New York. March 6, 2002. Also, personal correspondence, Don Boyd to Vernon Smith, March 8, 2002.
[12] National Association of State Budget Officers, *State Budgets – Update*, January 25, 2002.
[13] Don Boyd, personal communication. March 8, 2002.

is now searching for ways cut Medicaid spending in FY2002, and also to slow the longer-term growth of Medicaid into FY2002 and beyond.

Even though the economics of state budgets dictate that Medicaid costs be constrained along with other state programs, cutting Medicaid is a difficult choice for state policy makers, for at least three reasons. First, it is difficult because Medicaid by its nature is counter-cyclical. As a means-tested program, the need for Medicaid goes up when the economy goes down. The program is most likely to expand just when the state is least able to afford its share of the costs. Second, Medicaid has a major role in financing the health care safety net. Hospitals, doctors, clinics, nursing homes and other health care providers depend on Medicaid to remain financially viable, and along with their patients bear the major fiscal brunt of cuts in Medicaid payment rates, coverage or eligibility. Third, cutting Medicaid is difficult because the state must cut expenditures by so much more than it saves for the state budget.

Because of the way federal matching funds support the program, a state realizes no more than half of the savings when it cuts Medicaid, but the economic, health care and political consequences of Medicaid cuts are in proportion to the size of the total cut in spending.

Federal matching rates—known as the Federal Medical Assistance Percentage, or FMAP—are at least 50% and currently exceed 75% for some states, and the average is 57%. (A state with a lower average per capita income will have a higher FMAP.)

The average federal matching rate is 57%, which means that on average a state must cut Medicaid spending by $2.33 to realize one dollar of state general fund savings. A state with a higher federal Medicaid matching rate must cut more to get a dollar of savings. For example, the ten states with an FMAP of 70% or greater must cut more than $3.33 to achieve one dollar in state general fund savings.[14]

For these reasons, few state policy makers are eager to cut Medicaid. The fact that state policy makers across the country have felt compelled to embark on substantial Medicaid cuts is a clear indicator of the severity of the current situation.

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[14] The ten states with FY2002 Medicaid matching rates (FMAPs) exceeding 70% include: AL, AR, ID, LA, MS, MT, NM, OK, UT and WV.

Since the gravity of state fiscal situations began to come into focus in the fall of 2001, state policy makers have proposed and enacted a series of cuts to Medicaid, and proposed more cuts for FY2003. Because many state legislatures are still in session, some decisions are not yet finalized. However, the tone and direction is evident, and can be summarized in the following ways.

Few budget-driven policy changes are intentionally directed at seniors. Indeed, Medicaid officials in several states told me in recent weeks that they have had a goal not to adversely impact seniors as they pursued Medicaid cost containment. However, because of where the money is spent, when Medicaid is cut it is difficult to avoid an impact on seniors and other vulnerable population groups, such as persons with disabilities. Over 70% of Medicaid spending is for persons who are elderly or have disabilities, and only 30% is spent on children and families. To achieve the needed savings, inevitably some of the Medicaid cuts will adversely affect seniors.

The urgency of current state budget problems has caused many states to give serious consideration to program cuts that would not have been thought possible a short time ago.[15] Examples abound, and have been widely reported in the popular press. Recent reports include:

- In 14 states officials are considering cutbacks in the Children's Health Insurance Program (SCHIP), including reductions in eligibility, outreach or funding. (Karen Tumulty, "Health Care Has a Relapse," *Time Magazine*, March 11, 2002)

- Medicaid budget cutting actions due to tight budgets are under consideration across the U.S. Proposed actions include:
  California: New $5 co-payments
  Florida: Limits on the medically needy program payment
  Illinois: Cuts to hospitals and nursing home payments
  Missouri: Eliminating home health services
  North Carolina: Eliminating selected services
  Vermont: Eliminating coverage for dentures

[15] Smith and Lannoye, *Medicaid and State Budgets: An October 2001 Update*, Kaiser Commission on Medicaid and the Uninsured, October 2001. Publication #4019.

Utah: Eliminating certain benefits, adding new fees and co-payments, but also adding coverage for low-income uninsured

Some lawmakers are now saying that they cannot support the program that accounts for 20% of state spending. State officials say that it is impossible for states to continue funding Medicaid programs at their current level and also have enough money to pay for other state programs, such as education, roads and schools—especially in a recession. (Simon, "Medicaid: States Cutting Benefits to Reduce Costs," *Los Angeles Times*, March 5, 2002)

- Medicaid "is in a fiscal crisis, forcing state legislatures convening around the country this month to look for ways to cut benefits and reduce payments to hospitals, nursing homes and pharmacies." The article described significant cuts being considered in Arkansas, Idaho, Maine, Illinois, and Oklahoma. The most prevalent cut was in pharmacy costs. Among a long list of proposals in Oklahoma was the elimination of the medically needy program. (Robert Pear and Robin Toner, "States Face Hard Choices on Medicaid Cuts," *New York Times*, January 14, 2002)

Among the strategies states are considering now, many are likely to affect seniors. Such actions being undertaken or considered right now to try to control the growth of Medicaid spending include the following:[16]

1. Prescription drug restrictions: Every state is feeling the effects of increasing drug costs, and many are moving aggressively to control these costs. Prescription drug costs have increased faster than any other component of Medicaid. Many states cite increases exceeding 20% a year for each of the past few years, and a doubling of Medicaid's costs for drugs in just four years. Most states are placing prior authorization requirements on selected brand-name prescription drugs, reducing the amount Medicaid pays for pharmaceutical products, reducing the amount paid to the pharmacist for filling the prescription, or limiting the number of prescriptions allowed per month. Some states are contracting with professional Pharmacy Benefit Managers (PBMs) to manage the benefit for them.

[16] The National Governors Association has summarized these proposed and actual cuts in a two-page document that is attached to this testimony. The NGA document and this section both draw from a review of state proposals to reduce Medicaid spending conducted by the National Association of State Medicaid Directors in February 2002.

About 80% of Medicaid's prescription drug costs are for seniors and persons with disabilities. (About 25% of Medicaid drug costs are specifically for seniors age 65 and older, and 55% for persons with disabilities.) The controls that Medicaid programs are initiating are designed to control or reduce utilization, usually by restricting access to brand name prescription drugs. Other strategies reduce payments for products or dispensing fees and these actions also may also limit access by limiting the choice of where a prescription may be filled.

At the same time, prescription drug coverage for seniors is a high priority in many states. Even though a Medicare drug benefit might be a better way to achieve the desired result, several states have implemented significant state-only drug programs for seniors at the same time they are reducing other areas of Medicaid spending.

2. Limits on payments to nursing homes and other providers: Many states are freezing or reducing provider payments in FY2002, and are indicating that payment increases are not likely next year as they continue to work on the state budget for FY2003.

Aside from prescription drugs, the largest areas of spending are hospitals and nursing homes, two areas where services are disproportionately provided to seniors. Strategies such as case management that reduce the use and costs of these services are hard to implement, especially within the current budget period. Therefore many states are using the strategy that results in immediate savings: reducing payment rates or postponing a scheduled rate increase.

A rate-cutting strategy is chosen because it gives the state genuine, certain savings. It also has an immediate effect on the providers who are committed to serve elderly and disabled Medicaid patients. (As indicated earlier, because of the federal matching rate, the effect on providers and patients is substantially greater than the savings realized in the state budget.)

3. Limits on home and community-based services: Every state has adopted a strategy of encouraging persons to receive long-term care services in their homes or communities, instead of a nursing home. The evidence shows that persons are happier in their own home, and the costs are less than in an institutional setting. However, there is also evidence that costs may increase if home and community-based services only add to the capacity of

the long-term care system, and the number of filled nursing home beds remains unchanged.

As a result, some states have chosen to constrain costs by limiting the number of "slots" in their Medicaid home and community-based services waiver programs. The result may be fewer alternatives available to seniors, and some who may not be served in the lower-cost home or community setting they would prefer.

4. New co-payments on services: Medicaid is allowed to impose limited co-payments. Federal rules dictate that co-payments are not permitted for children or women who are pregnant. Therefore, when co-payments are imposed they directly affect the adults enrolled on Medicaid, including those who are elderly and disabled.

A number of states have chosen to increase co-payments as part of their cost reduction strategy. These co-payments may apply to prescription drugs, eyeglasses, dental services, dentures, vision services, or a variety of other medical services. When co-payments are required, seniors as well as other adult Medicaid enrollees are expected to pay them.

5. Cuts in eligibility: Several states have pointed to increasing enrollment as a key factor in increasing costs, and have taken steps to limit the number of person who might become eligible by making eligibility criteria more restrictive.

Several states have proposed scaling back eligibility for children and pregnant women. Some states have scaled back outreach for children for Medicaid or the State Children's Health Insurance Program, as one approach to limiting enrollment.

Seniors and persons with disabilities will be directly affected by restrictions or elimination of the medically needy category of Medicaid eligibility, which is under consideration in several states. Under the medically needy coverage, a person can become eligible for Medicaid if the medical bills "swamp'' available income. In effect, Medicaid is a catastrophic coverage for persons with very large medical bills. Eliminating or restricting medically needy coverage will affect a relatively small number of persons, but they usually are persons with serious medical situations, or persons with

large medical bills, such as might be incurred by someone with a complex medical condition or someone in a nursing home.

Additionally, a few states are examining the possibility of rolling back eligibility for an optional group of low-income Medicare-beneficiaries who qualify for Medicaid, where Medicaid pays for Medicare premiums and co-insurance.

Conclusion

For states, the current fiscal situation has highlighted a fundamental problem with the current structure for financing Medicaid.

One of the strengths of Medicaid is that within the overarching federal framework, each state is able to structure its program to reflect the priorities, culture, health care delivery system and economics that are unique to each state, within what it can afford in terms of its state general funds. As a result, each Medicaid program is different in its coverage, eligibility, payment rates and how it administers its program. The ability of a state to tailor its program to its own circumstances is a strength of the current structure.

However, state financing of Medicaid is an Achilles' heel in this structure that is highlighted during an economic downturn. The Achilles' heel is that Medicaid is dependent on the ongoing availability of state general fund revenues. State officials make Medicaid policy and budget decisions based on state general funds, and Medicaid spending is controlled by the availability of state general funds. Medicaid's long-term viability requires a secure source of funding, one that would increase with health care cost increases and when the need for the program goes up during an economic downturn.

The current economic downturn has highlighted how state general funds do not meet the test of a secure source of funding for Medicaid. In times of economic downturn, when state general funds do not keep pace with Medicaid spending trends, states must find ways to reduce Medicaid spending, even if it means cutting services that have obvious adverse impacts on vulnerable populations, including seniors, and the health care providers who serve them.

When Medicaid was adopted by the U.S. Congress in 1965 as a companion to Medicare, no one expected Medicaid to become one of the largest programs in state budgets, no one expected Medicaid to allocate 35% of its spending on low-income Medicare beneficiaries who happened also to qualify for Medicaid, and no one expected states to have the fiscal capacity to finance a program whose costs would increase at twice the rate of state revenues over the long run—but that is what has happened.

States regard Medicaid as an excellent program, and they have demonstrated their commitment to Medicaid year after year by adopting options made available by Congress to cover additional population groups and by making appropriations of state funds that increased faster than other state programs. However, even with the most optimistic assumptions about the rebounding economy, increases in state revenues will be dwarfed by Medicaid expenditure growth over next decade.

This is one reason the nation's Governors in February 2002 described the current situation as "unsustainable"[17] and called for a Commission to examine Medicaid and how it should be financed and administered in the future. A key area for this Commission no doubt will be how Medicaid interacts with Medicare in providing services to seniors.

States seemingly have run out of strategies to control Medicaid spending growth. They are unable to keep up within the current structure for financing Medicaid. The prospect is that states may be forced by simple economics to continue to scale back their programs, and the current round of cost cuts may be just the beginning. To the extent that occurs, the brunt of program cutbacks will be borne by those on whose behalf most current expenditures are made, and those are low-income persons who are disabled and elderly.

Mr. Chairman and members of the Committee, I thank you, and would be pleased to respond to any questions you may have.

[17] National Governors Association, "State Efforts to Manage Medicaid Expenditures," February 2002.