Testimony of
GOVERNOR PAUL E. PATTON
COMMONWEALTH OF KENTUCKY

On Behalf of the
COMMONWEALTH OF KENTUCKY AND
THE NATIONAL GOVERNORS ASSOCIATION

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Chairman Breaux, Senator Craig, and members of the Special Committee on Aging, I thank you for inviting me to testify before your committee on the fiscal status of Medicaid and long-term health care financing. We are grateful that you are providing leadership on this critical health care issue.

Let me first introduce myself. I am Paul Patton, Governor of the Commonwealth of Kentucky and Vice-Chair of the National Governors Association (NGA).

As I think you know – the states have a Medicaid crisis on our hands. It's a very serious situation – in all 50 states – and it calls for short-term relief and long-term solutions.

During years when revenue was increasing, states were able to keep up – more or less – with growing Medicaid expenditures. It wasn't easy, given the pressure to fund education, public protection, and so on. It also wasn't easy given the rapid growth of Medicaid costs. The return of medical inflation and the new dynamic of pharmacy spending growth of 20 to 25 percent per year have made it a real challenge.

The demands have been such that Medicaid now takes, on average, 20 percent of state budgets across this country. Let me illustrate the problem by relating our experience in Kentucky since I was elected Governor six years ago.

Kentucky state revenue has increased 26 percent in those six years while the Consumer Price Index has increased 16 percent. We have increased expenditures for elementary and secondary education by 20 percent; social programs 18 percent; and Medicaid by 47 percent!

When revenue was growing, we couldn't say no to the real medical needs of our needy citizens. Now that revenue growth is stagnant, we have no other choice. While my legislature was willing to give Medicaid more than its share of its growth revenue over the past six years, it is unwilling to take money away from other needed programs or to raise taxes to pay for double digit annual increases in the cost of providing services our Medicaid program has promised to our people.

Because of the downturn in the national economy, Kentucky General Fund revenue in the second year of the next biennium is estimated to be <u>less</u> than the budgeted expenditures for the current fiscal year!!!

Our challenge is to find a way to not cut services when we have less money than we had the year before. There is absolutely no way we can absorb a 10 percent increase in Medicaid with

a zero increase in revenue. Our only choices are to increase taxes – which isn't going to happen – or decrease services....unless the federal government steps up to the plate and helps us. We will be forced – and I think this is true of all states – to cut optional services and/or optional eligibles by the end of the next biennial budget cycle. This is not what government is supposed to be!

So while I am here today to discuss the burden of long-term care costs to the Medicaid program, I want to make an urgent plea for some short-term relief. Specifically, a temporary increase in the federal match rate to states – known as FMAP. I know, Mr. Chairman, that you, and perhaps other members of the Committee, serve on the Finance Committee. So I ask you to carry this request for us. It is very important to states that are having a hard time keeping their heads above water.

But there's another reason that Medicaid programs are in trouble – and this one doesn't always find its way onto the list of likely suspects. The demand for long-term care services under Medicaid will bankrupt state budgets unless another form of financing is found. And because of this, Mr. Chairman, I am here to tell you that this program is indeed broken and unsustainable.

Traditionally, states took care of the poor and the federal government took care of the needs of the elderly. Medicaid was created to provide health care to those on welfare – mostly moms and kids and mostly folks we expected to return to the workplace – but it is fast becoming the program to fund long-term care services in this country. And because the cost of caring for this group is so great, it is crowding out our ability to care for our traditional state mandates. Today older and disabled beneficiaries account for roughly one-third of Medicaid beneficiaries...and more than two-thirds of Medicaid expenditures.

And it didn't happened by design, Mr. Chairman. It has happened by default.

- It happened first when Title XIX (19) or Medicaid was created in the mid-sixties. A financing strategy was needed to pay for folks in nursing facilities who had exhausted their resources. That responsibility was given to Medicaid, but little did anyone guess that nearly Medicaid would today fund 60 percent of the nursing facility beds in this country.

- It happened again in the late eighties, when we realized we couldn't exhaust a **couple's** resources so that the husband or wife in a nursing facility would be eligible for Medicaid. What would the remaining spouse in the community do with no resources? So spousal impoverishment policies were developed and many more individuals became eligible for long-term care via Medicaid.

- Again in the eighties, the Medicare Catastrophic Act gave states significant new responsibility for those on Medicare but with low incomes. While the needs of these individuals -- known as "dual eligibles" -- are great and need to be addressed, it has added significantly to state responsibility. While these dually eligibles represent only 17 percent of total Medicaid beneficiaries, they account for approximately 35 percent of Medicaid expenditures.

- It can also happen when Medicare trims its service coverage. The Balanced

Budget Act of 1997 reduced spending for Medicare, which resulted in cuts to home health services. As a result, a number of services and supplies for homebound elderly were no longer covered by Medicare. Those services were picked up by the states for all the dually eligibles.

- And finally, Mr. Chairman, recent proposals for a Medicare drug benefit for seniors have set off alarms in state capitols. Some of the plans call for a shared federal-state program, administered by the states. I don't think I need to tell you that the Governors believe that a Medicare drug benefit should be covered by and administered by Medicare. It seems to me that Medicare is an incomplete program if it doesn't provide assistance to elderly persons for the three most important components of their health care: physician services, hospital services **and** pharmacy services.

A good bit of the financial burden of caring for the elderly through Medicaid comes to the states through their own decisions to provide coverage of optional programs. In fact, 83 percent of optional Medicaid spending is devoted to the elderly and disabled. Pharmacy is an optional program – though all fifty states provide pharmacy services. Various spenddown programs for the poor elderly are also optional programs. But ending these programs is not a realistic or at least an attractive option for governors and state legislatures. What we need is flexibility in federal law to tailor the resources we have to stretch them as far as possible. Right now, it's all or nothing – if you run a program via Medicaid, you cannot limit benefits or require adequate cost sharing, for example. I strongly urge that for those optional programs and services, the states should be given broad latitude to design an affordable program.

Because so much of the Medicaid program has been enacted piecemeal, it has created a patchwork of eligibility categories and rules and regulations that are only good for the consultants that we need to hire to explain it to us. It is certainly not good for elderly Americans trying to negotiate their way through programs they badly need.

It makes little sense to me that services for the same group of people should be so divided. How can we manage the care of individuals when one branch of government is handling physician, hospital, lab services and so on, and another is trying to manage pharmacy and long-term care? Home health services are provided through both Medicaid and Medicare. Can you imagine if health plans tried to divide care in this way? Drug use can reduce hospitalizations. Physicians can reduce the number of prescriptions written. Home health can reduce or delay inpatient nursing care. But there is no way any of these savings will be achieved with the current fractured system. There is no unified incentive and that is basic to managed care.

The states have, by the way, tried to deal with long-term care services in as responsive a way possible. Through the creation of Home and Community Based Waiver Programs, and services such as Adult Day Care, states have sought to give the elderly choices other than institutional placement; options which the states hoped would cost less than inpatient nursing care. We found in Kentucky, however, – and I don't think it's unique among the states – that the demand for these services is so great, that the alternatives end up being program expansions with no commensurate reduction in facility spending. Why? For every individual in a nursing home, it is estimated that there are four people in the community who need care.

There is a sense of urgency in my remarks today, Mr. Chairman. At a time when state Medicaid budgets are rising annually at double digit inflation rates and most states face budget

deficits, we must find long range solutions or we will be ill-prepared to meet the long-term care needs of 77 million baby boomers when they retire.

This is not an issue that can be put on the back burner until Social Security and Medicare are reformed. It is an issue that will not wait. Again, I congratulate your leadership, Mr. Chairman, and that of the members of this Committee, for having the foresight to begin resolving this crisis before the real flood of elderly persons comes into the system. No doubt, hard questions about services, funding, expectations, patient responsibility, shared program administration and federal-state responsibility will need to be asked and answered.

When all the Governors met late last month in this city, under the leadership of NGA Chairman and Michigan Governor John Engler, there was absolute agreement that a crisis is at hand, that it must be confronted, and that the program must be changed if we are to serve the needs of our families. There was also consensus in calling for a national Medicaid Commission to recommend fundamental long-term reform of the program.

The scope of this Commission would include a look at the current and future capability of state government to finance health care for populations and services that Medicaid currently covers; to more clearly delineate between federal and state roles and responsibilities; and to make recommendations on how health care coverage should be provided to those who are dually eligible for both Medicaid and Medicare.

It was recommended that this Commission be formed separate from the NGA and should include bipartisan representatives from the Administration, members of the House and Senate, Governors and nationally recognized experts in the field.

I urge you to join us in supporting the creation of a Medicaid Commission to ensure that the very best minds in our country can elevate this issue to the top of the national agenda. The Commission can sort through the complex issues, make recommendations for changes essential to the future of the Medicaid program, and – I hope -- enjoy substantial bipartisan support at both our levels of government. We would look forward to working with you as partners because we know we need to tackle this together if we are to succeed. I would be glad to respond to questions.

Medicare and Medicaid

When the federal and state shares of Medicaid are considered together, Medicaid enrollees and expenditures currently exceed Medicare's enrollees and expenditures.

- For FY 2002, Medicaid beneficiaries will total 44 million, while Medicare beneficiaries will total 40 million.

- For FY 2002, total Medicaid expenditures (state and federal) will total $250.4 billion, while Medicare expenditures will total 227.2 billion.

Medicaid Expenditures for the Elderly and Disabled

Older and disabled beneficiaries account for roughly 1/3 of beneficiaries but more than 2/3rds of expenditures.

- While the elderly and disabled account for about **30 percent** *or about one-third* of all Medicaid beneficiaries — expenditures for older and disabled beneficiaries account for about *two-thirds* (70 percent) of total program expenditures.

- In 1998, 57 percent of Mandatory Medicaid spending was devoted to the Elderly and Disabled, while 30 percent was devoted to children and 13 percent to parents.

- In terms of optional Medicaid spending, (which includes coverage for prescription drugs)—83 percent of spending was devoted to the elderly and disabled, while 8 percent was devoted to children and 9 percent to parents.

- Medicaid is now the nation's primary public financier of long-term care. The program should no longer be considered a welfare related program.

- A national survey, conducted in December of 2000, indicated that 37 percent of Medicaid enrollees were receiving cash welfare assistance—while 63 percent were not.

Medicaid and the Dually Eligible

While a small proportion Medicaid beneficiaries, the dually eligible account for approximately 35 percent of Medicaid expenditures.

- Of all Medicaid beneficiaries, approximately 17 percent are dually eligible for both the Medicare and Medicaid programs. While a small proportion of Medicaid beneficiaries, the dually eligible account for approximately 35 percent of Medicaid expenditures.

- Medicaid pays Medicare premiums and co-pays for dually eligible persons. Dually eligible persons are also eligible to receive Medicaid's long-term care and prescription drug benefits.

- Dually eligible persons are often in poor health and use a high proportion of long-term care and prescription drug services—neither of which is available under the Medicare program.

Long-Term Care Expenditures

The primary sources of funding for long-term care are Medicaid and out-of-pocket spending.

- A March 2002 article published in *Health Affairs,* indicated that 1998 total long-term care expenditures for elderly and disabled persons (nursing home care and home care) totaled $150 billion.

- The primary sources of financing for long-term care were Medicaid (40percent) and out-of-pocket spending (26 percent)—accounting for two-thirds of all national long-term care spending (66 percent).

- Medicare expenditures for skilled nursing care—which is limited to 100 days and usually related to a hospital stay or outpatientprocedure—

accounted for only 20 percent of overall expenditures.

- Private insurance covered 8 percent of expenditures.
- Other sources accounted for 7 percent of expenditures.

Medicaid Expenditures for Long-Term Care

The vast majority of Medicaid long-term care spending goes to nursing homes.

- Of the $150 billion spent in 1998 on long-term care—$100 billion went to nursing home care.

- Of the $100 billion spent on nursing home care, Medicaid expenditures totaled 44 percent and out of pocket spending totaled 31 percent—accounting for three – quarters of all nursing home expenditures.

- Medicare expenditures totaled 14 percent
- Private insurance expenditures totaled 7 percent
- Other sources accounted for 5 percent of expenditures.

- At present, the national average annual cost of nursing home care is nearly $56,000.

Prescription Drug Coverage: The Other Long-Term Care

Most older persons have at least one chronic condition and many have multiple conditions. Many of these conditions are treatable with prescription drugs.

- Beginning in 1998, and continuing into the present, prescription drug coverage—which is not available under the Medicare program—exceeded physician

services as the most utilized Medicaid Service.

- The most frequently occurring chronic conditions among the elderly are arthritis, hypertension, heart disease, cancer, diabetes and stroke. Most of these conditions are treatable with prescription drugs.

- Older Americans now buy about 29 prescriptions annually.

- In 2000, Medicaid expenditures for prescription drugs totaled approximately $21 billion, representing about 10percent of Medicaid expenditures in 2000.

- CBO indicates that Medicaid program growth over the next ten years is expected to grow by 8.5 percent.

- At the same time, for FY 2002, CMS estimates that spending for prescription drugs is estimated to increase by 16 percent or about double the increase in the overall Medicaid program.

- In a recent survey, Medicaid officials in 36 states listed pharmacy costs as the top cost driver in the Medicaid program in 2001. In an additional 12 states, the rising cost of prescription drugs was considered to be among the top two or three cost drivers in Medicaid.

- Increases in the cost of prescription drug prices are attributable to:

  - Increases in the number of prescriptions per enrollee.
  - Inflation in the cost of each prescription.
  - According to the National Institute of Health Care Management, escalating sales from 23 relatively new medications accounted for about 50 percent of the spending increase in prescription drugs nationally.

Recent Increases in Medicaid Costs for the Elderly and Disabled

Between 2001 and 2002, the increased cost of caring for elderly and disabled Medicaid beneficiaries was the single largest factor behind the $12.4 billion dollar increase in Medicaid growth.

- Of the $12.4 billion increase, $7 billion or 56 percent of the increase was attributable to the elderly and disabled.

- Among the elderly and disabled, 83 percent of this increase is attributable to inflation – including inflation in the cost of prescription drugs.

Steps States are Taking to Control Medicaid Costs Today

In order to balance their FY 2003 Budgets, states are taking a number of strategies steps to control Medicaid spending.

According to the Kaiser Family Foundation:

- *Imposing restrictions on prescription drugs.* As the cost of prescription drugs has increased faster than any other component of Medicaid, strategies include:

  - Contracting with Pharmacy Benefit Managers (PBMs).
  - Imposing prior authorization requirements on selected brand-name drugs.
  - Limiting the number of prescriptions that beneficiaries are allowed per month.
  - Reducing the amounts paid to pharmacists for filling prescriptions.
  - Reducing the amount Medicaid pays for pharmaceuticals.

- *Limiting payments to nursing homes and other providers.* In addition to the rising cost of prescription drugs, the largest areas of Medicaid spending are payments to hospitals and nursing homes—where services are overwhelmingly provided to seniors. For 2002, states have postponed or reduced provider payments and for 2003, many are considering provider payment freezes.

- *Limiting Access to Home and Community Based Services.* Although very popular, states are deferring expansions in their Home and Community Based Services Waiver programs as one means of controlling costs.

- *Reducing Eligibility.* Strategies include lowering the income standard for the dually eligible, and delaying implementation of Buy-In programs for the working disabled.

- *Increasing Co-Payments*. For pharmaceuticals and for other medical services including dental services and vision services.

Medicaid and Long-Term Care Growth Tomorrow

Spending for long-term care is expected to rise rapidly over the next decade.

- According to a March 2002 analysis of National Health Expenditures conducted by staff of the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) -- spending for nursing home and home health care is expected to rise by nearly $100 billion, from $135.1 billion in 2001, to 237.2 billion in 2011.

- The same analysis also indicates that during the same period, prescription drug prices are expected to nearly triple, rising from $141.8 billion in 2001 to $413.9 billion in 2011.

- This recent National Health Expenditure survey indicates that Medicare costs are

expected to rise from $245.6 billion in 2001 to $450.1 billion in 2011.

- At the same time, the federal and state Medicaid expenditures are expect to rise from $226.1 billion in 2001 to $521.8 billion in 2011 -- exceeding costs in the Medicare program.

- This means that by 2011, the state share of the Medicaid program alone ($220.3 billion) will be close to total state and federal funding for the Medicaid program in 2001 ($226.1. billion).

- Moreover, the January 2002 Budget and Economic Outlook issued by the Congressional Budget Office (CBO) indicates that within the Medicaid program -- the federal share of long-term care expenses alone -- is expected to rise from $42 billion in 2002 to $98 billion in 2012. This rise would account for about one-third of all federal Medicaid spending over the period.

Long-term Care Expenditures: Looking Ahead

Demand for long-term care these services will increase when the baby-boom generation begins to grow old.

- Issues pertaining to long-term care financing will impact not only publicly financed programs -- but individual Americans their families as well – after Medicaid, most long-term care expenditures are paid for out-of-pocket.

- For every individual in a nursing home, it is estimated that there are approximately 4 people in the community who require care.

- Caregivers to individuals aged 65 and over, are most often daughters who devote 20 hours a week to caring for a loved one. Caregivers spend on average 4.5 years providing care. Researchers estimate that the annual cost of caregiving in terms of lost productively to U.S. businesses totals $11.9 billion annually.

- Over our lifetimes, and as we age, we can all be expected to need a mix of services including hospital care, short-term skilled nursing care, long- term care in or homes or in assisted living facilities or in institutional care. Long-term care is not an either or proposition – nor is it a Medicare vs. Medicaid issue – it is most of all – an issue about the health care needs of our mothers and fathers and eventually ourselves.

- Long-term care expenditures have to be viewed through a wider lens – one that will adequately reflect the current and future needs of our society.

- This is among the many reasons NGA has endorsed the notion of a Medicaid Commission.

Unfortunately, this is all coming to pass as states face an ongoing erosion of their revenue base. Even when states begin to recover from this recession—a time which, based on our

experiences in previous recoveries, is likely to lag national economic recovery by as much as 18 months—that recovery will not replace the elimination of nearly $90 billion in estate tax revenues, much less the growing erosion of the single most important source of state revenues, sales taxes, to electronic commerce.