

**THE ECONOMIC DOWNTURN AND ITS IMPACT  
ON SENIORS: STRETCHING LIMITED DOLLARS  
IN MEDICAID, HEALTH, AND SENIOR SERVICES**

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**HEARING**

BEFORE THE

**SPECIAL COMMITTEE ON AGING  
UNITED STATES SENATE**

**ONE HUNDRED SEVENTH CONGRESS**

**SECOND SESSION**

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**WASHINGTON, DC**

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**MARCH 14, 2002**

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# **THE ECONOMIC DOWNTURN AND ITS IMPACT ON SENIORS: STRETCHING LIMITED DOL- LARS IN MEDICAID, HEALTH, AND SENIOR SERVICES**

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**THURSDAY, MARCH 14, 2002**

U.S. SENATE,  
SPECIAL COMMITTEE ON AGING,  
*Washington, DC.*

The committee met, pursuant to notice, at 9:37 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Larry E. Craig, presiding.

Present: Senators Craig and Carper.

## **OPENING STATEMENT OF SENATOR LARRY E. CRAIG**

Senator CRAIG. Good morning, everyone. The Senate Special Committee on Aging will convene.

Today we will be examining what I think is a very critical issue to our Nation's seniors. I also want to thank Senator John Breaux, the chairman of the committee, for facilitating this hearing and allowing me to chair the hearing this morning.

Of course, all of us are hopeful that the recession, which began last year, is at last beginning to ease. Sadly, however, for many, the downturn's repercussions remain very, very serious. For seniors, the recession's painful effects are perhaps nowhere more starkly evident than in the Medicaid program. Contrary to the perception of some, Medicaid is not just a lifeline for America's poorest citizens, but rather, for America's seniors, Medicaid is now also very much a middle class program. Funded jointly by States and the Federal Government, Medicaid today pays nearly two-thirds of all nursing home and long-term care bills. So when Medicaid is in trouble, so too is middle America. In trouble it is. As the economy has contracted, so too have tax revenues, leaving States facing a collective \$40 billion deficit this year—a near record level.

Regrettably, these shortfalls are now colliding painfully with the demands of State Medicaid programs, which have been growing rapidly in recent years. Last year, national Medicaid expenditures jumped about 10 percent, and similar increases are expected this year. In my home State of Idaho, the rate is even higher—approximately 15 percent. Nationally, Medicaid is now growing between two to three times faster than other key State programs, including higher education and corrections.

Most troubling perhaps are Medicaid's prescription drug costs, which are rising much faster than the program as a whole, by approximately 20 percent annually.

Caught in a catch-22 of rising Medicaid costs and sharply declining growth in State revenues, at least 42 of the 50 States are now projecting Medicaid budget shortfalls this year. In the face of these pressures, States are turning to an increasingly aggressive array of strategies to control costs and stretch limited dollars. Many of these will be discussed by our witnesses today.

I am especially pleased to have with us today Dr. Jack Riggs, Lieutenant Governor of my home State of Idaho, along with Karl Kurtz, Director of our State's Department of Health and Welfare.

Our second panel will discuss similar pressures confronting America's area agencies on aging and our State units on aging.

Finally, before we start, let me stress that it is always easy to look at problems like these and just say the answer is more money. However, in lean times, the reality is that big new expenditures, whether Federal or State, are extremely unlikely. Rather, our challenge is to find effective ways to work within our limited resources to deliver the best services we possibly can for our seniors.

Again let me thank our witnesses for being with us today.

[The prepared statement of Senator Craig follows along with prepared statements of Senator Breaux and Senator Stabenow.]

#### PREPARED STATEMENT OF SENATOR LARRY CRAIG

Good Morning, and thank all of you for joining us here this morning to discuss the economic downturn and its effects on America's seniors. Thank you, too, Senator Breaux for facilitating my chairing this morning's hearing.

Of course, all of us are hopeful that the recession that began last year is at least beginning to ease. Sadly, however, for many, the downturn's repercussions remain very, very serious.

For seniors, the recession's painful effects are perhaps nowhere more starkly evident than in the Medicaid program. And contrary to the perceptions of some, Medicaid is not just a lifeline for America's poorest citizens. Rather, for America's seniors, Medicaid is now also very much a middle class program. Funded jointly by the states and the federal government, Medicaid today pays nearly two-thirds of all nursing home and long-term care bills. So when Medicaid is in trouble, so too is middle America.

And in trouble it is. As the economy has contracted, so too, have tax revenues, leaving states facing a collective \$40 billion deficit this year, a near-record level. Regrettably, these shortfalls are now colliding—painfully—with the demands of state Medicaid programs that have been growing rapidly in recent years. Last year, national Medicaid expenditures jumped about 10 percent, and similar increases are expected again this year. In Idaho, the rate is even higher, approximately 15 percent. Nationally, the Medicaid is now growing between two and three times faster than other key state programs, including higher education and corrections. Most troubling, perhaps, are Medicaid's prescription drug costs, which are rising much faster than the program as a whole, by approximately 20 percent annually.

Caught in a Catch-22 of rising Medicaid costs and sharply declining growth in state revenues, at least 42 of the 50 states are now projecting Medicaid budget shortfalls this year.

In the face of these pressures, states are turning to an increasingly aggressive array of strategies to control costs and stretch limited dollars. Many of these will be discussed by our witnesses today. I am especially pleased to have with us today Dr. Jack Riggs, Lt. Governor of my own state of Idaho together with Karl Kurtz, director of our state's health and welfare programs. Also, our second panel will discuss similar pressures confronting America's area agencies on aging and our state units on aging.

Finally, before we start, let me stress that it's always easy to look at problems like these and just say the answer is more money. However, in lean times, the reality is that big new expenditures, whether federal or state, are extremely unlikely.

Rather, our challenge is to find effective ways to work within our limited resources to deliver the best services we possibly can for our seniors.

Again, sincere thanks to our witnesses for coming today, and I look forward to your testimony.

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#### PREPARED STATEMENT OF SENATOR JOHN BREAUX

Good morning and thank you for being here today. This committee has held a series of hearings on long-term care and will continue to examine the questions surrounding financing and delivery of care for older Americans. Today's hearing, which will explore how best to stretch dollars when it comes to services for seniors, is a timely one. I want to thank Ranking Member Craig for calling today's hearing and thereby allowing us to delve into this issue further, as it is clearly one with no easy answers.

In a time of declining state revenues and limited resources at the federal level, states are struggling to find ways to cut costs. States are being forced to make some difficult choices—including cutting back on services affecting seniors. The Medicaid program—which is a primary payor of long-term care—has not been spared from this cost-cutting in the states.

Today we will hear data, demographics, statistics and projections—all of which are necessary to understand the scope of this issue. It is not enough, however, to simply lay out the problem. We are facing a national crisis when it comes to the questions surrounding long-term care. States' financial woes are especially pressing in light of the wave of baby boomers who will be needing long-term care services in the decades ahead. We must continue our dialogue and explore potential solutions, which I plan to do in this Committee's upcoming hearings.

Today's hearing is just one more step in our efforts to stimulate debate and discussion regarding how best to reform long-term care for our nation's seniors. I look forward to having our witnesses share their thoughts on this vital and increasingly challenging question. This committee's broader series of hearings and efforts to stimulate discussion hopefully will help us to formulate ideas to ensure that long-term care will be available to each of us should we ever need it.

Thank you.

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#### PREPARED STATEMENT OF SENATOR DEBBIE STABENOW

Chairman Breaux and Senator Craig, thank you for holding today's hearing on the "Economic Downturn and Its Impact on Seniors: Stretching Limited Dollars in Medicaid, Health, and Senior Services." As a member of the Budget Committee, and a strong support of many health care and senior programs, I think it is critically important that we examine these issues.

It is my pleasure to introduce one of today's witnesses, Vernon Smith, Ph.D. Dr. Smith is from Michigan where he has been an expert on Medicaid and other health issues for a very long time. As the former Director of Michigan's Medicaid program, he has a comprehensive understanding of the program and will provide valuable information for the committee.

Currently, Dr. Smith is a Principal with Health Management Associates, where he conducts research on economic, health care, and public policy trends and their impacts on many important health programs. Most recently, Dr. Smith has published reports on the effect of the economic downturn on Medicaid and S-CHIP (entitled MICHild in Michigan) and other programs such as welfare reform. I know that his work provided important background for the committee as we prepared to hold this hearing and we are all looking forward to your testimony today.

I would like to take a few minutes to highlight some important points before we begin. We have known for some time that the funding structure for Medicaid could lead to hardship during economic downturns. When state's face declining revenues they often must debate making cuts to the program. The irony is that these cuts must be considered when demand is increasing. States also face the difficult reality that for every dollar they cut from their own budgets for Medicaid; they lose, on average, the \$1.33 federal match as well. In other words, for a limited saving to the state, dramatic cuts in the program could be the result.

This committee is especially concerned about cuts to Medicaid because many low income seniors are covered through a combination of Medicaid and Medicare. Through this coverage, some seniors are very fortunate because they have coverage for prescription drugs. Ensuring that all seniors who are eligible for Medicare get good prescription drug coverage is one of my top priorities. States are currently con-

sidering many options to slow their Medicaid spending and it would be especially devastating if states opted to limit prescription drug coverage.

Related to that issue, I would like to mention that I intend to introduce a bill, the Senior Nutrition Act, that would help seniors account for the high cost of their prescription drugs when they are seeking food assistance through important USDA nutrition programs. I urge my colleagues to contact my office if you are interested in getting more information and joining me as an original cosponsor.

In closing, I know we are discussing a complex and important issue. Many have suggested that we need to reexamine the basic funding structure for Medicaid so that resources are not limited during economic downturns when the need for this important health care program is at its highest. I think this committee will provide an excellent forum to begin that debate and I look forward to hearing from all of our witnesses today.

Our first panel this morning, as I have mentioned, includes Lieutenant Governor Jack Riggs of Idaho and Karl Kurtz, the Director of the Idaho Department of Health and Welfare; Gail Wilensky, who is the John M. Olin Senior Fellow, Project HOPE—and former Administrator of the Health Care Financing Administration; Barbara Lyons, Deputy Director, Kaiser Commission on Medicaid and the Uninsured; and Vernon Smith, a principal with Health Management Associations and former Medicaid Director for the State of Michigan.

Governor, I will turn to you and allow you to direct your testimony. I understand that you and Director Kurtz will participate jointly here.

Please begin.

**STATEMENT OF DR. JACK RIGGS, LIEUTENANT GOVERNOR, STATE OF IDAHO, BOISE, ID; ACCOMPANIED BY KARL KURTZ, DIRECTOR, IDAHO DEPARTMENT OF HEALTH AND WELFARE, BOISE, ID**

Dr. RIGGS. Thank you, Mr. Chairman. It is certainly an honor and privilege to be before you today on these important matters.

I come before you in the dual role as both a physician and as an elected official in the State, looking at the policy issues. I will make opening comments, defer to the director, and then have a few closing thoughts.

When looking at any complex problem, my initial approach is to do the analysis first, and of course, in current times, it seems like much of the news is bad.

There are some things that I think are very obvious. First, we are in a recession, and many of the existing systems and models in health care delivery seem to be failing, and we have an “age wave” coming just a few short years away.

Of course, I would say fundamentally that the economy, through our tax structure which creates the revenues, is—and it may be overly simplistic—but I think it is important for us to remember, that it is the economy that provides the revenues for any of the programs that we have, and I believe it is a very direct correlation. When the economy is flat or in recession, there will be a direct correlation and a direct decrease in the level of services to our existing models.

Typically, I believe, my observation of the legislative process is that when there is a flattening of the economy and a decrease in revenues, the initial approach is to cut budgets, and therefore, services will be directly hampered.

My concern there, of course, is that when—and I speak now as a physician—when you displace individuals who are receiving Medicaid benefits, especially in long-term care, they will have a diminished health response and will probably end up in our medical system in inpatient hospitals. So I would actually expect to see Medicare costs go up. If you are displacing those who are receiving long-term care or getting prescription drug benefits through Medicaid, especially the elderly, they will end up in Medicare, and I think that that is very clear.

When you cut reimbursement to providers, or as we are seeing the possibility in the prescription drug market, when you cut the reimbursement and go below what is overhead, access will certainly be hampered. Of course, then you get into a vicious cycle, because when you diminish access, the health of the individual, and collectively, will decline, which will then cause greater costs on the Medicare side, because you will have people who are basically more unhealthy.

Of course, as you mentioned, for States, the typical approach is to ask for more money, and we in Idaho certainly recognize that this is probably not the best time for that, because we do recognize the national situation.

I think part of the approach, therefore, needs to be that we should as policymakers help address some of what should be the expectations in the public. My sense as a physician over the years has been that the individual patients I have dealt with have grown to have great expectations not only of our system and our Government but also of technology, that it will keep them alive forever. Unfortunately, as a physician, I have to remind people over and over that we are born, and we live, and we die, and that is the natural order of things, and if we get later in years, and the end is inevitable, it is probably better to recognize that and to approach it gracefully.

I do believe that without a doubt, as people age, if they can stay at home, it is far better, and I think home-based services is clearly the best approach. And the money spent in preventive care is much better than waiting for the emergency to occur and the patient to wind up in the hospital.

I would suggest that looking at efficiencies in our current programs is really the first step, and that is something that we are doing in Idaho. I will turn to Director Kurtz, because I know he wants to share some ideas and things that we are doing looking for those efficiencies.

Mr. KURTZ. Good morning, Mr. Chairman, and I thank you for the opportunity to come and talk about the impact of our aging population on our State budgets.

It used to be that Idaho's economy followed the Nation's, but it always took us a couple years to catch up. That is no longer true. The economic downturn has hit Idaho hard. As the Lieutenant Governor said, tax revenues are shrinking, budgets are being cut, and as we all know, medical costs and therefore Medicaid spending are headed in the opposite direction.

Every State agency in Idaho has been forced to cut back, Medicaid, and the elderly who depend upon Medicaid are not immune. For the past several years, Idaho's Medicaid expenditures, as you



noted, have gone up at a 15 percent annual increase. In a strong economy, it is difficult to keep up with that kind of spending increase; in a recession, it is impossible.

The Governor and the Idaho legislature have directed our agency to limit Medicaid growth to a 6 percent increase in the coming year. To do this, we must reduce the scope of our Medicaid coverage. Senior citizens are not targeted specifically, but they will feel the impact. We will reduce pharmacy costs, restrict adult dental coverage to emergency services, and limit what Idaho pays when a Medicaid patient is covered by both Medicare and Medicaid.

In the interest of time, I will only discuss that pharmacy changes. I have presented written testimony about the other three areas, but I will limit my comments primarily to the pharmacy.

According to a 1998 Medicaid study, 12 percent of Medicare enrollees rely on Medicaid to pay for their prescriptions. The cost of prescription medications is spiraling out of control. In 1999, Idaho Medicaid spend \$64 million prescriptions. That level of spending ranked it as the third-largest expenditure category in our Medicaid program. Two years later, in 2001, that cost had gone up 58 percent, topping \$101 million.

Idaho individuals age 65 and older account for less than 6 percent of Medicaid enrollees, but they account for nearly 25 percent of our prescription drug costs. Those costs continue to climb. We project spending on medications to be \$121 million this year, ending June 30, and it will be our No. 1 expenditure in our Medicaid program next year, at over \$139 million. In 4 short years, our prescription drug costs have more than doubled.

The proportion of dollars spent on senior citizens will rise even faster. In the 1990's, according to the recent Census, the growth rate in the number of citizens 65 and older in Idaho was higher than 37 other States, so that population is increasing.

The dollar figures that I have quoted may sound small in comparison with other figures that you hear on a daily basis here, but let me assure you that in Idaho, that money is a large sum. In fact, our total Medicaid budget in Idaho is second only to the appropriation for public education.

So what are we doing to control Idaho's Medicaid pharmacy costs? No. 1, we will reduce the drug acquisition payment that pharmacists receive. We will intensify our review of pharmacy claims. We will deny prescription refills until an individual has used 75 percent of the previous prescription. The fourth step is a big one—we will implement a prior authorization system that kicks in after a Medicaid client has four prescriptions in any one month. Prior authorization will be required for anything above four. About 10,000 Medicaid clients, many if not most of whom are senior citizens, have more than four prescription drugs.

A Medicare drug benefit will help Idaho and all other States as we try to gain some control over Medicaid spending.

With that, Mr. Chairman, this concludes my testimony. Again, I appreciate the opportunity to provide an Idaho perspective on this critical issue of Medicaid and its impact on seniors.

Senator CRAIG. Thank you, Karl.

Dr. RIGGS. Thank you, Mr. Chairman. I have just a couple of closing thoughts.

I think that a fundamental question that we as policy setters need to be asking is "where are we headed?" I think we have a clash of the past and the future that is occurring, and we are seeing that right now. By "the past," I mean some of those models that were created many years ago, in fact decades ago, of our health care delivery system and especially the Medicare and Medicaid models.

What is happening is that you are being asked to put more money, in fact billions of dollars, into what I would call a very old model, and I do not believe you would be asked to put billions into 50-year-old technology in communication, transportation, or defense.

By "the future," I am referring to the age wave. The baby boomers, who are just a few years away from being Medicare age, is a wave in our demographics that I believe will overwhelm the system. I would use the analogy that many people criticized the Y2K preparation for the future. I would argue that because of that preparation, that is what really averted a real problem. I think there is still time for such preparation for the age wave, but we are seeing the front end of that wave right now.

One or two examples of innovation—the Eden Alternative of Dr. William Thomas, which is the alternative where pets and children are brought into nursing homes, I think is being very well-received and is an example of an innovation. I would point to medical savings accounts; changing the attitude of younger people so that as they look toward their later years, they are actually being prepared for and thinking about the future. I would propose, as I am sure other people have, that a redesign of Medicare, which I know is a politically contentious discussion, really needs to be done, because that model cannot continue.

In closing, I would say that keeping our economy strong regardless of the model is critical. So whenever there is a discussion, if we can be proactive in keeping our economy strong, that is the revenue stream that funds whatever system exists, so that is critical.

The age wave that is coming, I would really characterize as a tidal wave that will crush our existing models, and it is only a few years away.

The encouraging point that I want to leave with you is that I believe there is still time to act, but there has to be innovation in that action.

Thank you, Mr. Chairman, and I am certainly happy to respond to any questions that you might have.

Senator CRAIG. Governor and Director Kurtz, thank you both very much. That is a pretty stark reality that Idaho faces and that we all face.

[The prepared statements of Lieutenant Governor Riggs and Mr. Kurtz follows:]



JACK RIGGS, MD  
LIEUTENANT GOVERNOR

To: **United States Senate**  
**Special Committee on Aging**

March 14, 2002

Thank you for the opportunity to address issues that currently touch, or will touch, every American life. My comments are made in a dual context, both as a medical physician, having seen first-hand the problems associated with aging, and as the Lieutenant Governor of Idaho, recognizing the importance of policy decisions that directly affect individuals.

I currently serve as the Co-chair of the CSG Health Capacity Task Force, and formerly as the Vice-chair of the CSG-West Committee on Aging. My oral and written comments will be supplemented by those of Karl Kurtz, Director of the Idaho Department of Health and Welfare.

My preferred problem-solving approach, both as a physician and as a policy maker, is to first analyze. This is then followed by setting priorities, creation of a plan, and finally implementing the plan. I believe this sequence must be followed in order to develop the most appropriate solutions.

My initial analysis contains both bad news and good news, which I believe may be already evident to all. First, the bad news is that the nation is in a recession, existing models of healthcare and long-term care for the elderly are failing, and there is an "Age Wave" coming. This "Age Wave", as described in 1990 by author and now aging expert Ken Dychtwald, PhD, is created by the convergence of the baby boom and increasing longevity. The number of Americans over age 50 will nearly double in the coming decades.

Of course, from an individual perspective, increase in life expectancy is probably good news. From the policy maker's perspective, it becomes problematic. Without significant adjustment, our current systems will simply be overwhelmed. Good news, however, can be found in that through early recognition of both the changing demographics and the new dynamics at play, there is still time for innovative solutions. The key term here is innovative. Old models will not work.

In light of this analysis, I would like to briefly comment on two priority areas: 1) the effects of a lagging economy on the delivery of services to the elderly, and 2) the attempt to maintain effective services in the face of declining revenues. Utilizing the existing delivery system models, there is a direct correlation between decreasing funds and decreasing services. Without adaptation and without creativity, there clearly are adverse impacts on vulnerable seniors. There is no question about this.

When a senior becomes dependent upon Medicaid for long-term care and prescription coverage, and then these traditional programs are squeezed, the individual gets squeezed. This negative impact undoubtedly results in greater MediCARE expense, because as the individual's health now deteriorates due to lack of attention, long-term care under MediCAID is replaced by inpatient hospital care under MediCARE. Within these existing models, keeping the economy strong is absolutely critical to providing services.

In this new era of flat-line budgets, however, there are approaches being implemented by the State of Idaho to maintain services at an appropriate level without harming individuals. The Idaho approach includes a systematic analysis of each existing program followed by developing efficiencies within the various programs. This focused approach is a direct result of the tight budget and is not without some pain, but the ultimate outcome will lead to better systems.

The simple answer for states is to ask Congress for more money, but that is not my goal today. In Idaho, we have made the conscious decision to view the current situation as an opportunity to review our systems and insure efficiency. The testimony by Director Kurtz outlines some of the programmatic changes that will actually improve care in many instances, specifically in the areas of prescription review and encouraging patients to have a primary care physician.

My more important goal today is to pose some thought provoking questions for you as policy makers, for you as leaders of our nation. My observation of the legislative process is that most often the focus is on budget development, and the results, therefore, are budget driven. Most of the time and attention is spent on accounting matters. Too often, creative thought is not encouraged, not allowed to thrive, and sometimes not even allowed to exist. Innovation and creation of better models are stifled.

The direct questions that I ask myself, and I now pose to you as leaders of our nation, are:

- 1) As a leader, what is your vision for our aging population? Where are you headed?
- 2) Will you rely on the past, or actively lead into the future?

Analysis of our current systems reveals an unhealthy reliance on the past, where current models were created many decades ago. The older systems may have been appropriate for their time, but demographics have changed dramatically. Imagine if Congress was asked to spend billions on 30 to 50 year-old technologies in communications, transportation, or defense. In 1965 when Medicare was created, average life expectancy was barely 70 years. Now it is 77 and continues to rise. Both the Medicare and Medicaid models have been painfully slow to evolve.

Leading into the future must be a priority. The "Age Wave" is coming ... a wave of aging Americans who will redefine what it means to be a senior citizen, just as this wave has altered society in every decade that it has traversed. Remarkable alteration to the very meaning of growing older will be no challenge for the baby boomers. They will simply redefine it, and pity the policy maker that gets in their way. The wise policy maker will have already taken the lead and will be riding the wave.

Recognition and analysis of the new wave demographics, followed by thoughtful preparation and plan implementation are required for success. Some say Y2K was overblown, or exaggerated. I believe that recognition of the pending problem followed by extensive preparation for Y2K is the very reason serious problems were averted. Hopefully, this will be the same case with the coming age wave. The very fact that this Senate Special Committee on Aging exists is a promising sign, but discussion must result in priority setting, plan development, and plan implementation.

There are examples of forward thinking and creativity already occurring in some areas in our country. In long-term care, the Eden Alternative, created by Dr. William Thomas, is spreading rapidly. Why? Because it offers a far more elder-friendly, a far more humane, setting than the traditional hospital style model that many old fashioned nursing homes still use. The hallmark of the Eden Alternative is to allow pets in the long-term establishment, but it also includes plants, gardens, children, and employee involvement. This is innovation and more needs to be done.

Another noteworthy example of innovation capable of leading toward potential long-term solutions is the often-neglected Medical Savings Account. The restraints placed on MSA's in the past have doomed them to failure. MSA's should be strongly encouraged, because they typify the forward thinking attitude that is vital to an individual's decision making through their life and as life advances. Individuals need to be thinking about, and more responsible for, their own health and their own future.

A third area worth commenting on, an area historically devoid of true innovation, is Medicare itself. I would propose that it is now time for the complete renovation and redesigning of Medicare. I certainly support some type of cost shared prescription drug coverage. But with improved health, improved medical technology, and increasing longevity, Medicare should become more responsive and flexible to suit the needs of older Americans. Now is the time to create new models so that recipients can become accustomed to them, and help determine the best system for the future.

For example, Medicare should become multi-phased depending on age. In the future, Pre-Senior (Phase I) coverage for those aged 65 to 75 would be followed by Senior (Phase II) coverage thereafter. The Pre-Senior package of benefits could be customized for the healthcare needs of the typical pre-senior, with flexibility and options for various levels of coverage. The Senior package would more closely resemble the current coverage, but would also include a comprehensive prescription drug benefit. No current Medicare recipient would be adversely affected, and the baby boomers would have the next ten years to adapt. This type of system would allow Congress to customize coverage to more closely meet the actual needs of those very Americans it is trying to serve.

As a closing message, I want to reiterate the critical importance of restoring and maintaining a strong economy to provide the revenue stream for any system, new or old. Secondly, we need innovation, vision, and leadership from our leaders. And finally, as I stated in the beginning, there is good news and bad news. The bad news is that the "Age Wave" is more than a wave, it is really a tidal wave, a tsunami that will crush the current models of Medicaid, Medicare, and long-term care. The good news is that there is still time for leaders to lead, but only if you are innovative, and only if you act now.

I thank you for allowing input, and I offer my personal and professional assistance in any capacity that may be beneficial to you.

Respectfully,

Jack Riggs, MD  
Lieutenant Governor  
State of Idaho



State of Idaho  
**DEPARTMENT OF HEALTH AND WELFARE**  
 Office of the Director

DIRK KEMPTHORNE  
 Office Location:  
 Governor

KARL B. KURTZ  
 Director

450 West State Street, 10th Floor  
 Boise, Idaho 83720-0036  
 (208) 334-5600  
 Fax: (208) 334-5928  
 Mailing Address:  
 PO Box 83720 10th Floor  
 Boise, Idaho 83720-0036

March 14, 2002

Karl B. Kurtz, Director  
 Idaho Department of Health and Welfare

**Formal written testimony to the United States Senate  
 Special Committee On Aging**

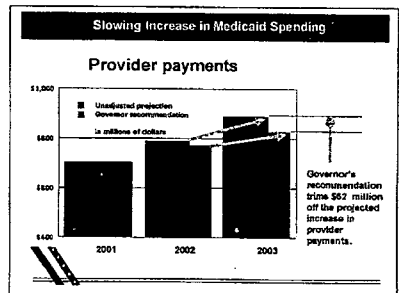
It is an honor to be here this morning to talk about the impact of the weak economy on Medicaid's senior citizen population.

You know, it used to be that Idaho's economic trends followed the nation's. It took us a couple years to catch up. That's no longer true. The economic downturn has hit Idaho hard. Tax revenues are shrinking; budgets are being cut. As we all know, medical costs, and therefore Medicaid spending, are headed in the opposite direction. Every state agency in Idaho has been forced to cut back. The Medicaid program – and the elderly who depend on Medicaid – are not immune.

For the past several years, Idaho's Medicaid expenditures have gone up 15 percent clip year. In a strong economy, it is difficult to keep up with that kind of spending increase. In a recession, it is impossible.

Idaho Governor Dirk Kempthorne and the Idaho Legislature have directed our agency to limit Medicaid growth to 6 percent in the coming year. To do that, we must reduce the scope of our Medicaid coverage.

The chart at the right illustrates the point. The blue bars represent projected provider payments if we do nothing. The red bars represent the spending



reductions forced on us by the recession.

The 2003 budget for Idaho's Medicaid program is about \$56 million more than the 2002 budget after mid-year, recession-driven budget cutbacks. That's the 6 percent increase. Even with that percent increase, the Medicaid appropriation is \$62 million lower than the unadjusted projection for 2003. The gap is pointed out by the green arrows.

The adjustments I am about to discuss will help us avoid a total of \$19 million in provider payments this year and \$62 million in 2003. Both figures include General Fund and federal match. Senior citizens are not targeted specifically, but they will feel an impact.

We will not make any adjustments to our eligibility criteria, which are the most restrictive in the nation. Nor will we eliminate a single coverage area. I want to emphasize that. We do not propose eliminating a single area of covered service.

Having made those decisions, we turned our attention to how we might limit the scope of Medicaid benefits. The actions we propose will help us avoid costs by putting in place the same kind of coverage limits you see in private insurance packages.

Looking at this picture of our 10 most expensive coverage areas helped us decide where to focus our attention in Medicaid. The projections assume nothing has been done to reduce spending. Together, these 10 categories will account for 85 percent of total Medicaid spending in Idaho in 2003.

As you see, we project prescribed drugs will be Medicaid's most expensive benefit next year. To give you a sense of why that is, Idaho Medicaid paid for more than 2 million prescriptions in fiscal year 2001. Senior citizens accounted for nearly 25 percent of our Medicaid drug cost that year, even though they represented less than 6 percent of our Medicaid enrollees

Medicaid projections (Title XIX only)		Medicaid Expenditures (in millions of dollars)		
Services provided by	Top 10 service categories	2001	2002	2003
State code	Prescribed drugs	\$102.9	\$118.2	\$152.1
Feds	Nursing Homes	\$121.5	\$125.2	\$138.9
Feds	Inpatient hospital	\$102.8	\$110.8	\$120.3
State code	Widely used services	\$53.7	\$71.8	\$81.1
Feds	Physician services	\$48.5	\$53.4	\$59.1
State code	Mental health	\$40.2	\$45.8	\$51.3
State code	CFR/DR	\$32.1	\$35.2	\$37.8
State code	Developmental Disability Agencies	\$28.5	\$32.9	\$37.5
Feds	Outpatient hospital	\$30.6	\$33.3	\$35.5
State code	Dental	\$17.9	\$20.1	\$22.5
Total Title XIX spending on top 10 service categories		\$578.7	\$647.5	\$728.6
Total Expenditures		\$706.4	\$751.7	\$838.8

A Medicare pharmacy benefit will help all state Medicaid programs immensely. According to a 1998 Medicare survey, 12 percent of Medicare enrollees rely on Medicaid to pay for their prescriptions.

The cost of prescribed medications is spiraling out of control. In 1999, Idaho Medicaid spent \$64 million on prescriptions. That level of spending made it the third highest spending category in our Medicaid program. Two years later, the cost had gone up 58 percent, topping \$101 million.



Those costs continue to climb. We project spending on medications will be No. 2 (\$121 million) this year and No. 1 in 2003 (\$139 million). In four short years, our prescription drug costs have more than doubled.

The proportion of dollars spent on prescriptions for senior citizens will rise even faster. In the 1990s, according to the recent census, the growth rate in the number of citizens 65 and older in Idaho was higher than 37 other states.

The dollar figures I have quoted may sound small or insignificant here in Washington. But let me assure you that, in Idaho, that money is a huge sum. In fact, our total Medicaid budget in Idaho is second only to the appropriation for public education.

So, what are we doing to control Idaho's Medicaid pharmacy costs? Here are the pharmacy changes we will make:

1. Reduce the drug acquisition payment pharmacists receive. When fiscal year 2002 began, this reimbursement rate was 89 percent of the average wholesale price. We dropped it to 88 percent.
2. Increase review of pharmacy claims.
3. Deny prescription refills until 75 percent of the original prescription has been consumed. We estimate about 3,600 prescriptions are refilled inappropriately each month. (That's 43,000 inappropriate prescriptions per year.) Several states use the 75 percent standard and report reduced fraud and abuse of Medicaid's prescription benefit.

The fourth step is a big one. Beginning this month, we are implementing a prior authorization system that kicks in after a Medicaid client has four prescriptions in any given month. Prior authorization will be required for any more. About 10,000 Medicaid clients have more than four prescriptions. We estimate about a third of those prescriptions are appropriate.

#### Medicaid Pharmacy Benefit

##### Pharmacy Changes

- Reduce drug acquisition payment;
- Increase review of pharmacy claims;
- Prohibit refills before 75% of prescription is consumed; and
- Require prior authorization for more than 4 prescriptions.

#### We need help from Congress

##### Prescription drug benefit

The steps I have described will help, but we need help from Congress, too.

A Medicare drug benefit will help Idaho and all other states as we try to gain some control over Medicaid spending.

We estimate these strategies will reduce FY2002 spending by a combined \$9.7 million. Annualized, the cost avoidance in the FY2003 budget should be around \$30 million. Both of those figures include General Fund and the federal match. The prior authorization system accounts for 90 percent of the cost avoidance next year.

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None of these steps eliminates anyone's access to needed medication. With prior authorization, senior citizens and others who need more than four prescriptions will continue to get the medications they need. We will minimize the impact of prior authorization by allowing an annual authorization for people with a long-term need for multiple medications.

When all these changes are said and done, Idaho Medicaid will still cover prescriptions. The coverage will not be eliminated. We're just going to manage it better. The steps I have described will help, but we need help from Congress, too.

Again, a Medicare drug benefit will help Idaho and all other states as we try to gain some control over Medicaid spending.

We also will implement changes that permit us to make headway on inpatient and outpatient hospital care expenses. Again, senior citizens will be affected, though they certainly are not targeted by the changes we will make.

We have been managing the length of stay in hospitals for a number of years. Currently, we check with hospitals on the fourth day of a patient's stay to determine the status of their discharge plan. Beginning in April, we will check on the third day.

When we went to this review on day four a number of years ago, we saw a big drop in the average time a Medicaid client stays in the hospital. We think the same thing will happen with a check on day three.

Let me emphasize that no Medicaid patient will be required to leave the hospital before they are medically ready. No physician will allow that. Neither will we.

By increasing our concurrent and retrospective review of hospital care, we will ensure proper hospital utilization and appropriate and timely discharge to lower-cost facilities.

We anticipate this enhancement of our hospital utilization management program will reduce costs by \$2.8 million in fiscal 2003.

Physician services is Idaho Medicaid's fifth most expensive coverage area. Under our FY2002 holdback plan and our FY2003 budget, we will bring Medicaid's physician reimbursement rates in line with Medicare. There are two steps in our rate change plan.

#### Medicaid Physician Services

##### Physician Reimbursement Rate Changes

- Lower reimbursement for specialty services down to Medicare rates; and
- Raise most reimbursement rates for primary care providers to Medicare rate.

1. We will lower reimbursement for specialty services down to Medicare rates in fiscal year 2002.
2. We will raise most reimbursement rates for primary care providers to the Medicare rate in fiscal year 2003. The remaining rates will be brought up to the Medicare level in fiscal year 2004.

Idaho's Medicaid program pays more – sometimes much more – than the federal government pays for the same procedure.

Let me give you two examples.

- ③ Medicaid paid for almost 25,000 emergency room physician visits last year.

If our rate matched Medicare's, each visit would have cost the state close to \$11 less. Paying at the Medicare rate would have saved us \$265,000.

- ③ Our rate for gallbladder surgery is almost \$200 higher than Medicare. Last year, we paid for 263 gallbladder surgeries. Paying at the Medicare rate would have lowered our expenses by \$50,000.

Together, that's more than \$300,000 in cost avoidance from just those two services – that savings would come simply by insisting on paying no more than the federal government. Switching to the Medicare rate for all specialty procedures will save Medicaid nearly \$4 million this year and \$10 million next year.

The second step in realigning our rates with Medicare begins in July, when we will raise most rates for primary care providers up to

#### Medicaid Reimbursement changes

##### Impact from Matching Medicare Specialty Rates

Emergency room physician visits:

24,449 – number of claims in FY2001  
 x \$10.86 – difference between Medicaid and Medicare rates

**\$265,516 cost avoidance**

#### Medicaid Reimbursement changes

##### Impact from Matching Medicare Specialty Rates

Gallbladder surgery:

263 – number of claims in FY2001  
 x \$194.92 – difference between Medicaid and Medicare rates

**\$ 51,263 cost avoidance**

#### Medicaid Reimbursement changes

##### FY2003 Impact from Matching Medicare Rates

\$10 million – cost avoidance from matching specialty rates  
 - \$ 2 million – cost of raising primary care rates

**\$ 8 million cost avoidance**

Medicare levels. That process will be completed in fiscal year 2004.

The cost in fiscal year 2003 will be \$2 million. Obviously, that takes away from the cost avoidance impact we'll get from switching to Medicare's specialty rates. However, it still leaves us with a net savings – or cost avoidance – of \$8 million in fiscal year 2003.

The bad economic news continued to pile up this winter. The Idaho Legislature's budget committee heard me present Governor Kempthorne's Medicaid recommendation on January 29. The program and coverage changes I have already described were included in that presentation. Less than 10 days later, the January tax revenue figures came in showing another shortfall. This prompted the budget committee to require an additional holdback for the current year and a further reduction in the budget for the year ahead.

The result of that is a further limitation on the scope of services covered by Idaho Medicaid, one that will affect senior citizens although, as before, they were not specifically targeted. The decision was made to limit Medicaid's adult dental coverage to emergency services only. This unfortunate but necessary step will reduce our Medicaid expenditures by an estimated \$500,000 this fiscal year and \$7.1 million dollars in the fiscal year that begins July 1, 2002.

We will change other aspects of Idaho's Medicaid program over the next several months. Certainly, it is true that the weakening economy had a lot to do Idaho choosing to take these actions now. However, it would be a mistake to blame it all on the economy. Some of these changes just make good business sense, and we would have made them at some point as we make the best use of taxpayer dollars.

Beside adoption of a Medicare pharmacy benefit, how else can Congress help states make effective use of limited resources?

- ③ Encourage – through tax incentives or some other means – the purchase of long-term care health plans.

Why? According to a 2000 study by the Health Care Financing Administration (Office of the Actuary), 39 percent of long-term care costs in America are paid for by Medicaid. Just 7 percent is covered by private insurance. After Medicaid, the next most common method of paying for long-term care is out-of-pocket. It does not take long for people who are paying out of pocket for long-term care in this manner before they spend down to the point of Medicaid eligibility.

Nationally, Medicaid spending on nursing home care will jump \$2.6 billion between this year and next. The following year it will jump another \$3 billion ... and another \$3-plus billion the year after that. The cost just keeps rising.

Yes, Medicaid is a federal/state program. And yes, Idaho's share of those billions will remain relatively small, but the strain it will put on Idaho's budget will be incredible.

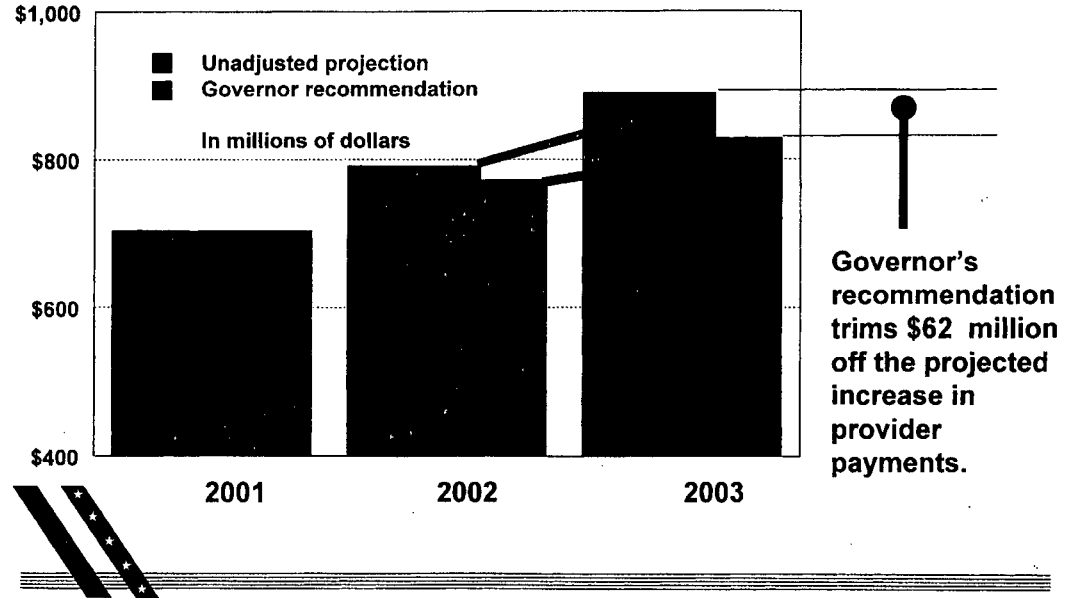
Today, long-term care accounts for more than 30 percent of Idaho Medicaid expenditures. Nursing home costs are the second most expensive coverage area in Idaho's Medicaid program. The fourth most expensive category is waived services for long-term care – Home and

Community Based Services. And while the cost of waived services is smaller, that cost is growing rapidly. Idaho's Medicaid program paid \$53 million for waived services in 2001. In 2003, we anticipate spending \$81 million. That's a 53 percent increase in just two years. These two service categories are used primarily by senior citizens. More people covered by long-term care policies will reduce upward pressure on Medicaid spending.

I urge Congress to continue its support for Medicaid coverage of Home and Community-Based Services. This committee heard testimony on this topic last July. These services shift costs away from more expensive institutional care and towards more effective, less expensive services in community settings.

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## Provider payments



**Medicaid  
projections**  
(Title XIX only)

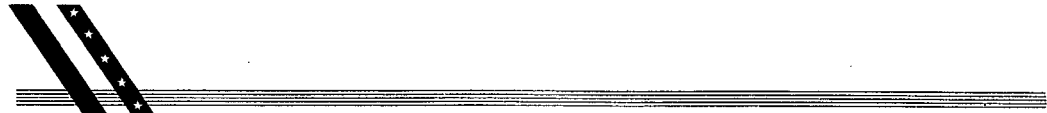
**Medicaid Expenditures**  
(in millions of dollars)

Service required by	<i><b>Top 10 service categories</b></i>	2001	2002	2003
State code	Prescribed drugs	\$100.6	\$118.2	\$139.1
Feds	Nursing Homes	\$121.3	\$125.2	\$138.9
Feds	Inpatient hospital	\$102.6	\$110.8	\$120.3
State code	Waivered services	\$53.2	\$71.8	\$81.1
Feds	Physician services	\$48.5	\$53.4	\$59.1
State rule	Mental health	\$40.4	\$45.8	\$54.3
State code	ICFs/MR	\$36.1	\$36.0	\$37.8
State code	Developmental Disability Agencies	\$28.5	\$32.9	\$37.5
Feds	Outpatient hospital	\$30.6	\$33.3	\$36.3
State code	Dental	\$17.9	\$20.1	\$22.5
Total Title XIX spending on top 10 service categories		\$579.7	\$647.5	\$726.8
Total Expenditures		\$704.4	\$791.7	\$890.6



## Pharmacy Changes

- Reduce drug acquisition payment;
- Increase review of pharmacy claims;
- Prohibit refills before 75% of prescription is consumed; and
- Require prior authorization for more than 4 prescriptions.







## **Prescription drug benefit**

**The steps I have described will help, but we need help from Congress, too.**

**A Medicare drug benefit will help Idaho and all other states as we try to gain some control over Medicaid spending.**





## **Physician Reimbursement Rate Changes**

- **Lower reimbursement for specialty services down to Medicare rates; and**
- **Raise most reimbursement rates for primary care providers to Medicare rate.**





## **Impact from Matching Medicare Specialty Rates**

**Emergency room physician visits:**

24,449 -- number of claims in FY2001  
x \$10.86 -- difference between Medicaid and  
\_\_\_\_\_ Medicare rates

**\$265,516 cost avoidance**



## Impact from Matching Medicare Specialty Rates

Gallbladder surgery:

263	-- number of claims in FY2001
x \$194.92	-- difference between Medicaid and
<u>          </u>	Medicare rates

**\$ 51,263 cost avoidance**



Senator CRAIG. Now, once again, let me introduce Dr. Gail Wilensky to the committee. She is former Administrator of the Health Care Financing Administration and currently John M. Olin Senior Fellow of Project HOPE, where she is one of the country's foremost authorities on health care, Medicaid, and Medicare.

Here come the solutions. Gail, welcome to the committee.

**STATEMENT OF GAIL R. WILENSKY, JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD AND FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION**

Dr. WILENSKY. Thank you, Mr. Chairman, for inviting me here.

As you indicated, I am at Project HOPE now. I also co-chair the Presidential Task Force to Improve Health Care Delivery for our Nation's Veterans. But I am here today to share ideas as a health economist and a former HCFA Administrator, and I am going to try to make about half a dozen points.

First, we all need to recognize that States are caught in a double-bind. They are finding their revenues squeezed because of the economic downturn at the same time that they are finding themselves pressed because of the rapid increase in Medicaid expenditures—11 percent this year, and the Congressional Budget Office predicts next year 9.5 percent, not quite so bad, but still quite steep.

Part of that increase reflects deliberate actions on the part of the States. In the last several years, States have expanded benefits, they have included populations that were not previously included, they have expanded their outreach, and they have increased payments to providers. I do not say these are bad things. I think these are basically good things that States did. They are now struggling because of the change in the economy, and because of increases, in some areas that one not their doing increased health care spending across the country for hospitals in particular and for prescription drugs, as we have heard, in Idaho as well as elsewhere.

There is no question that the States are finding themselves hard-pressed, and unlike the Federal Government, most States by then constitutions are required to be in balance at all times, which is facing them to act.

When you look at what the States are doing, they are mostly relying on reductions in payments to providers as a way to do a quick fix. Looking around the country, you see this going on in Indiana, where payments for nursing homes, hospitals, and pharmacies were cut in the fall, and more proposals are being made to continue these reductions. Some States are using preferred drug lists, some requiring prior authorization, as we have heard Idaho is going to be doing. Maine is also proposing to reduce reimbursements, and Illinois is proposing some additional reductions to reimbursements.

The problem, of course, is that Medicaid has typically been the lowest payer around, so the reductions in provider payments raises the question about whether access will be affected. In general, probably in the short term, it will be OK, although I am worried about nursing homes. This is an area that has been of particular concern to this committee because of the frail nature of the vulnerable populations in nursing homes. It is particularly a problem because unlike the other areas, Medicaid is the dominant payer for nursing homes—a point that you have already made—so that if

Medicaid reduces payment, there are not a lot of other places to turn to to make up those payments. In fact, a recent report have seen from Lewin Associates, confirms what most people have suspected, which is that Medicare has been cross-subsidizing Medicaid's underpayments in nursing homes. If some of the extra Medicare payments for nursing homes are not continued this year, as may happen, it is likely to catch the nursing homes particularly short, an industry that has already proven itself to be quite fragile.

In the short term, I am very concerned and would encourage the committee to continue its vigilance in providing oversight for the nursing home population.

States need to be careful about how they proceed. Some of their strategies can backfire. We have seen this happen in the past. A decade ago, one of the States limited the Clozerol, one of the antipsychotic drugs, and had schizophrenics ending up back in institutions—hardly humane treatment for the schizophrenics and certainly not cost-saving for the State.

There was a report in *The Wall Street Journal* a couple of weeks ago about a state that had required the use of generics whenever available, only to find out that sometimes, branded drugs that have just come off patents are actually cheaper than generics.

So state have to act very carefully. The better ideas unfortunately are not quick fixes. They involve looking at clinical protocols to try to have the best use of some of the new, expensive therapeutics; they require using disease management for high-cost illnesses such as congestive heart failure and diabetes.

There is an interesting proposal called a "partnership program." It encourages middle-class individuals to protect their assets by not having to count their value as part of their spend-down if they buy long-term care insurance, thereby lessening the likelihood that they will end up on Medicaid if in fact they need extensive long-term care.

But none of these, to be perfectly honest, is the kind of quick fix that many States need right now. I am a trustee of the United Mine Workers Health and Retirement Fund. They have a very old and frail population and are using a combination of generic drugs, preferred products, geriatric case management and disease management for diabetes and congestive heart failure. This program seems to have saved some money, and I believe it has improved health care, but in all honesty, it has taken a couple of years to implement.

The Federal Government had better watch out. My experience as a HCFA Administrator is that when States get pressed, they become very fiscally creative. When I was there, it was called "provider taxes" and "voluntary donations." Now it is called "upper payment limit," where the States basically bill Medicaid for more than they are actually reimbursing; some of the public facilities get the increased match, either make and get back or do not make the increased payment to the public facilities, and only the Feds have spent more money.

If the Federal Government wants to temporarily increase the match rate under Medicaid, it ought to do so outright so that everybody plays by the same rules, and all States benefit appropriately. The Federal Government ought to be very careful not to

tolerate, these other types of strategies, even understanding the States' fiscal crisis.

Finally, it is obvious that a Medicare prescription drugs benefit would help the States a lot. I believe that prescription drug coverage ought to be part of a reformed Medicare program, but inadequate and unfair benefits are not Medicare's only problems. You heard reference to the "age wave" which is coming, the 78 million baby boomers who will start to retire at the end of the decade. Medicare has already made many promises and it is not clear how it will be able to pay for all these promises. While it is important to reform Medicare, adding a new benefit to a fiscally fragile program, without tackling the rest of reform Medicare needs, is a bad idea, and I encourage you not to do it.

Senator CRAIG. Gail, thank you very much for your insights that I know come from current and past experience. Your studies are very valuable to us.

[The prepared statement of Dr. Wilensky follows:]

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

**Testimony**

**Presented To**

**THE SPECIAL COMMITTEE ON AGING  
UNITED STATES SENATE**

**By**

**Gail R. Wilensky, Ph.D.**

**John M. Olin Senior Fellow, Project HOPE**

**On**

**March 14, 2002**



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 hospitals 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.

Illinois is proposing additional reductions in payments to doctors, dentists, pharmacists and nursing homes following earlier cuts in Medicaid spending. New Jersey is also proposing cuts in Medicaid payments to providers.

Illinois is proposing additional reductions in payments to doctors, dentists, pharmacists and nursing homes following earlier cuts in Medicaid spending. New Jersey is also proposing cuts in Medicaid payments to providers.

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 various 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.

Senator CRAIG. Now let me once again introduce Dr. Barbara Lyons, Deputy Director of the Kaiser Commission on Medicaid and the Uninsured, an organization that has focused heavily on the interplay of the economic forces of health care delivery.

Barbara, welcome before the committee.

**STATEMENT OF BARBARA LYONS, DEPUTY DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WASHINGTON, DC**

Ms. LYONS. Thank you for the opportunity to testify this morning on Medicaid's role for seniors.

Medicaid is the nation's major program for financing health and long-term care for 44 million low-income Americans, including over 4 million seniors. Low-income seniors depend on Medicaid for help in three primary areas—paying for medications, paying for long-term care, and paying for Medicare's financial obligations.

The downturn in the economy, coupled with the increased pressure on State budgets, place Medicaid's protections at risk. The scope of Medicaid assistance for seniors today varies by income and by State. The poorest elderly receive coverage for the full range of Medicaid benefits. These beneficiaries, known as "dual-eligibles," rely on Medicaid primarily for wrap-around benefits not covered by Medicare, namely, prescription drugs and long-term care. A smaller share of seniors receive Medicaid help primarily for the payment of Medicare premiums, referred to as "buy-in assistance."

The elderly comprise 10 percent of Medicaid beneficiaries overall, but account for one-quarter of Medicaid spending, largely due to their intensive use of acute and long-term care services. In fact, nearly three-quarters of Medicaid spending on the elderly is devoted to long-term care services.

As was stated earlier, Medicaid is the only program that covers ongoing nursing home care, paying for nearly half of nursing home costs nationally and financing care for over two-thirds of the nation's nursing home residents.

Medicaid assistance with community-based long-term care has been growing but remains limited, with fiscal concerns constraining the broader development of these efforts.

States' fiscal condition began to deteriorate at the end of 2000. The slowing of State revenue growth combined with increasing Medicaid costs has created significant budget stress in many States. These trends are projected to continue, with Medicaid projected to increase at an average annual rate of about 8 to 9 percent over the next several years. Spending on services, especially nursing home care, prescription drugs, as well as the buy-in subsidies for the elderly, are all factors in Medicaid spending growth.

According to our analysis of CBO's spending projections, the increased cost of caring for the elderly was the second-largest factor, following the disabled, behind the \$12.4 billion increase in Federal Medicaid spending last year.

The trends in Medicaid expenditures track the trends in private health care spending. Cost increases in the private market put pressure on Medicaid to keep pace. To maintain access, Medicaid programs are pushed to raise payment rates for providers and to pay for the escalating costs of prescription drugs.

Medicaid long-term care spending has also been rising and may reflect the pressure to improve nursing home quality. As Gail stated, low Medicaid payment rates to nursing homes have historically limited access, and longstanding concerns about the quality of care in nursing homes persist.

Federal law gives States broad discretion to restrain Medicaid expenditures, but decisions to trim eligibility, reduce benefits, or cut payments to providers are not easy. States must also consider the implications of losing the Federal matching funds to their health care financing systems. 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.

Historically, States look to cutting provider payments to hospitals and nursing homes as a first step in reducing spending. As States prepare their budgets for fiscal year 2003, many are again likely to turn to curbing provider payments, with implications for access and quality. In addition, as was heard earlier today, most States are focusing on controlling prescription drug spending, adopting strategies including prior authorization, capping the number of prescriptions, higher copayments, and reducing payments for prescription drugs and dispensing fees.

It is unclear what the ultimate effect of some of these strategies will be on overall spending and quality or whether they will have the unintentional effect of limiting access to essential medications. Low-income elderly beneficiaries often require multiple prescriptions to manage health conditions and therefore constitute a substantial portion of those most affected by these strategies.

The pressure on Medicaid resulting from the aging of the population and rising health care costs is unlikely to abate. Consideration of short- and long-term alternatives to assure adequate coverage and financing are likely to be essential to Medicaid's future success in serving as this nation's safety net program.

To conclude, budgetary problems, coupled with the pressure of rising health care costs, portend difficult times ahead. Medicaid is an essential source of coverage for seniors but also for low-income families and others with disabilities. Given the vulnerability of the population served by Medicaid, it is critical that attempts to constrain costs not compromise the quality of care available even in tough economic times.

Thank you. I look forward to working with the committee on these issues in the future.

Senator CRAIG. Dr. Lyons, thank you very much.

[The prepared statement of Ms. Lyons follows:]





**THE KAISER COMMISSION ON  
Medicaid and the Uninsured**

**Medicaid's Role for Seniors:  
Challenges in a Fiscally Constrained Environment**

Barbara Lyons, Ph.D.  
Deputy Director  
The Kaiser Commission on Medicaid and the Uninsured

Vice President  
The Henry J. Kaiser Family Foundation

For

"The Economic Downturn and Its Impact on Seniors"  
Special Committee on Aging  
United States Senate

March 14, 2002

### 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.

#### **Medicaid's 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.

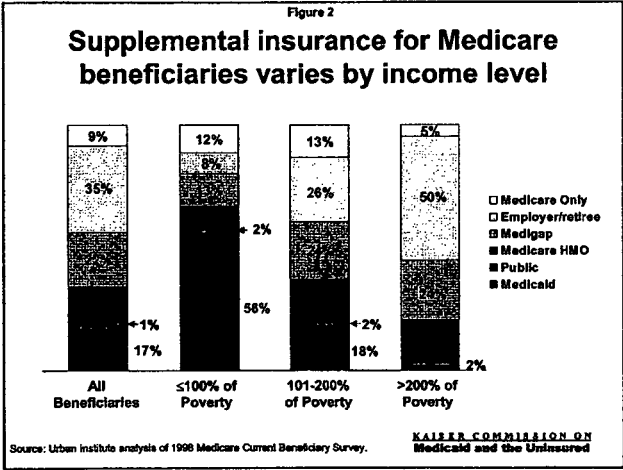
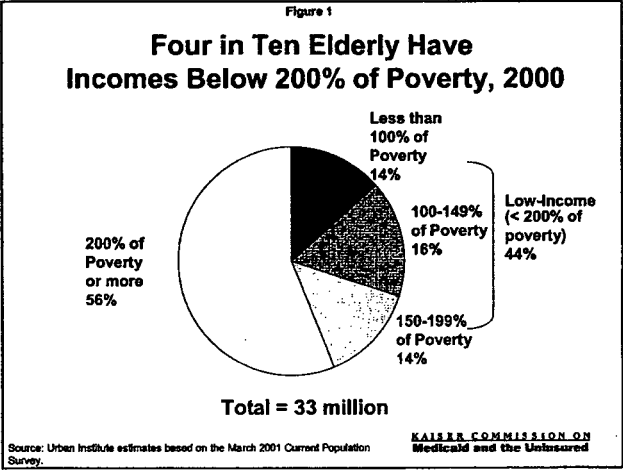


Figure 3

### Medicaid's Role for Medicare Beneficiaries

Program	Who's Eligible?	Asset Test	What Does Medicaid Pay?	Entitlement?
Full Medicaid Benefits	≤ 73% of poverty* (SSI eligibility level)	Assets below \$2,000 (individual) or \$3,000 (couple)	Wrap-around benefits, Medicare Part B premium and cost-sharing	Yes
	Elderly or disabled ≤ 100% of poverty**	Assets below \$2,000 (individual), \$3,000 (couple)**	Same as above	Yes
Qualified Medicare Beneficiaries (QMBs)	≤ 100% of poverty	Assets below \$4,000 (individual) or \$6,000 (couple)	Medicare Part B premium and cost-sharing	Yes
Specified Low-Income Beneficiaries (SLMBs)	100-120% of poverty	Assets below \$4,000 (individual) or \$6,000 (couple)	Medicare Part B premium	Yes
Qualifying Individuals (QI1s, QI2s)	120-135% of poverty (QI1s), 135-175% of poverty (QI2s)	Assets below \$4,000 (individual) or \$6,000 (couple)	Medicare Part B premium (QI1s), portion of the Medicare Part B premium (QI2s)	No

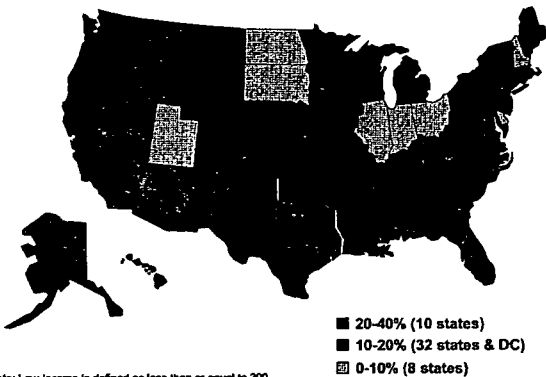
\* Some states (209b) may set lower levels.

\*\* States also have the option to provide full Medicaid benefits up to 100% of poverty based on their 1972 rules and may use "less restrictive" methodologies for counting income or resources.

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Figure 4

### Percent of Low-Income Elderly with Medicaid



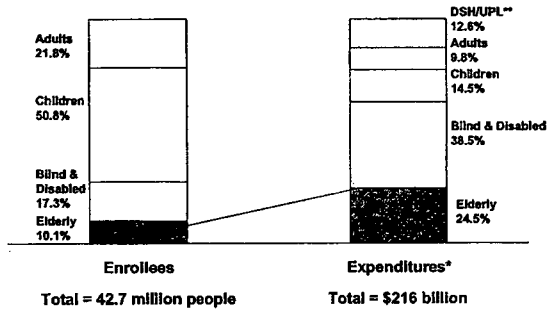
Note: Low-income is defined as less than or equal to 200 percent of poverty.

SOURCE: Urban Institute and KCMU estimates based on pooled 2001 and 2002 March Current Population Surveys.

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Figure 5

### Medicaid Enrollees and Expenditures by Enrollment Group, 2001



\*Total expenditures exclude administrative expenses, payments to the vaccines for children program, and a one-time receipt from SCHIP.

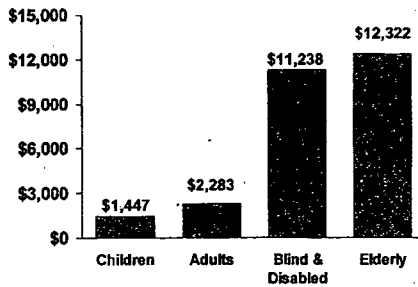
\*\*Disproportionate Share Hospital payments and Upper Payment Limit payments.

SOURCE: KCMU analysis of CBO baseline, January 2002.

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Figure 6

### Medicaid Expenditures Per Enrollee, 2001

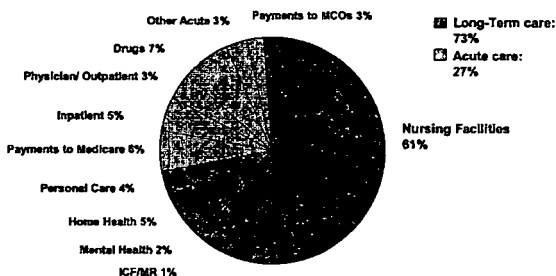


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SOURCE: CBO January 2002 Baseline.

Figure 7

## Medicaid Spending on Services for the Elderly, 1998



Total Spending on the Elderly = \$46 billion

Note: Does not include DSH payments. Lab and X-ray services included in site of receipt of service.

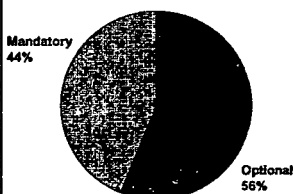
SOURCE: Urban Institute estimates, 2000, based on HCFA-2082 and HCFA-64 reports.

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Figure 8

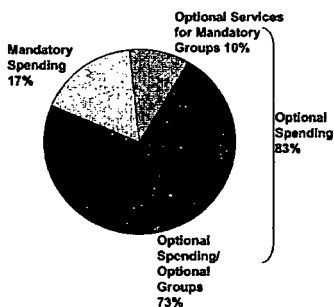
## Elderly Medicaid Beneficiaries, 1998

### Enrollment



Total = 4.2 million

### Spending



Total \$46.1 billion

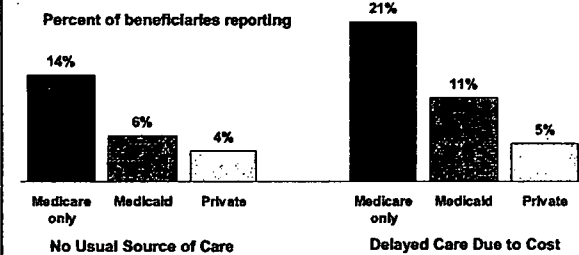
Note: Expenditures do not include disproportionate share hospital (DSH) payments, administration costs, or accounting adjustments.

SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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Figure 9

### Access to Care for Medicare Beneficiaries,\* 1999



\* Community residents only.

Source: Barents Group of KPMG Consulting analysis of the 1999 Medicare Current Beneficiary Survey, prepared for the Kaiser Family Foundation.

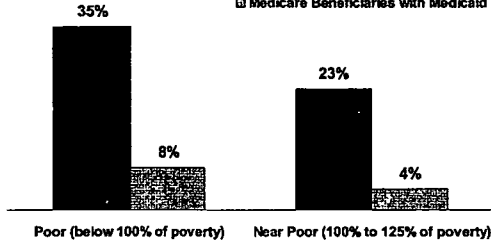
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Figure 10

### Average Annual Out-of-Pocket Costs for Low-Income Medicare Beneficiaries,\* 1997

Out-of-Pocket Spending on Health  
as a Percent of Income

■ All Medicare Beneficiaries  
▨ Medicare Beneficiaries with Medicaid



Non-institutionalized beneficiaries ages 65 and over.

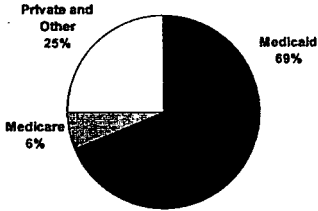
Source: AARP 1997. Lewin estimates based on 1993 Medicare Current Beneficiary Survey Cost and Use data projected to 1997.

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Figure 11

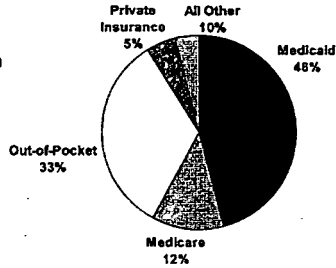
## Medicaid's Role in Long-Term Care

### Nursing Home Residents



Total = 1.5 million residents

### Nursing Home Expenditures



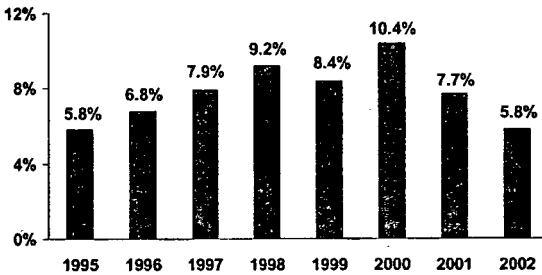
Total = \$ 87.8 billion

Source: HCFA, National Health Accounts, 2000. Nursing home care includes intermediate care facilities for the mentally retarded (ICFs/MR). Georgetown University Institute for Health Care Research and Policy.

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Figure 12

## Average State Year-End Balances as a Percentage of Expenditures, FY 1995 -2002



SOURCE: NASBO, December 2001. Figures for fiscal year 2001 are preliminary actuals; figures for fiscal 2002 are based on appropriations.

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Figure 13

### Federal Medicaid Spending is Beginning to Rise Again

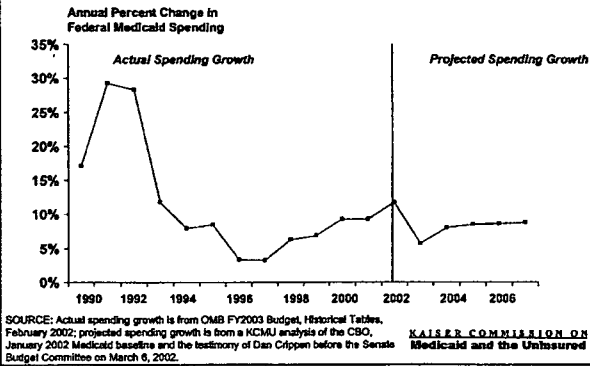


Figure 14

### Medicaid as a Share of All State General Fund Expenditures

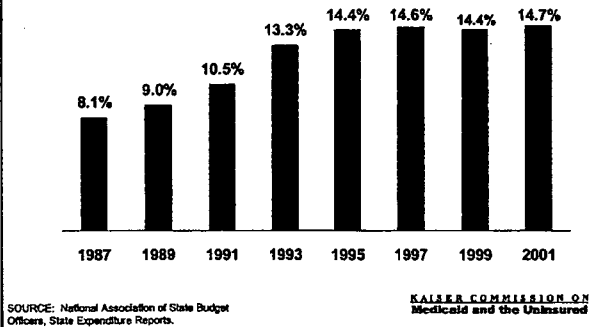
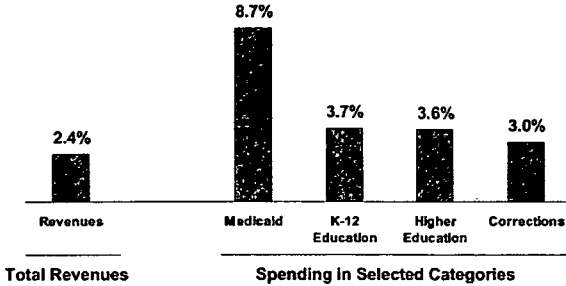


Figure 15

## Projected Growth in State Revenues versus Spending, FY 2002

Projected percent increase  
over previous year:

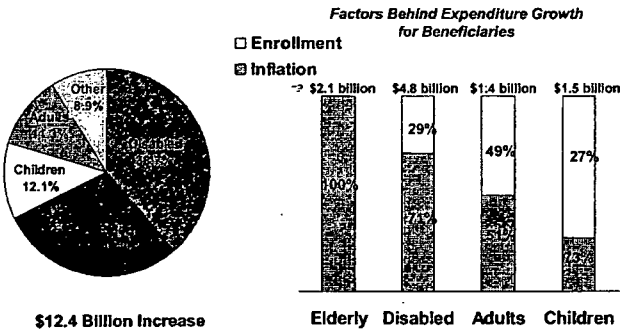


SOURCE: National Conference of State Legislatures, revenue projections based on information provided by 46 states and spending projections based on data provided by 40 states. Data gathered in Summer 2001.

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Figure 16

## Sources of Growth in Federal Medicaid Expenditures, 2001-2002

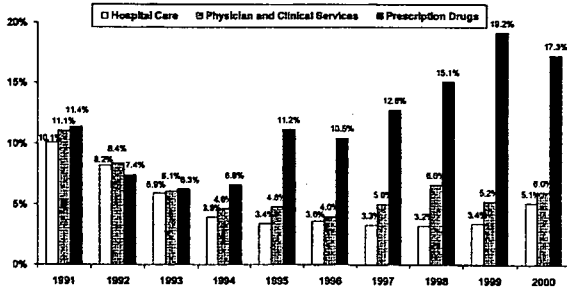


SOURCE: KCMU analysis of CBO Medicaid baseline, January 2002. Note that CBO's baseline was prepared prior to the Administration's release in January 2002 of a new regulation designed to reduce federal Medicaid spending on UPL arrangements in fiscal year 2002 and beyond. Thus, CBO's future Medicaid baselines are likely to show federal spending on UPL arrangements accounting for less of overall Medicaid spending growth in fiscal year 2002 than presented here.

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Figure 17

### National Spending for Selected Health Services, Annual Percent Change, 1991-2000



Note: Prescription drugs accounted for 11% of total personal health-care spending in 2000.

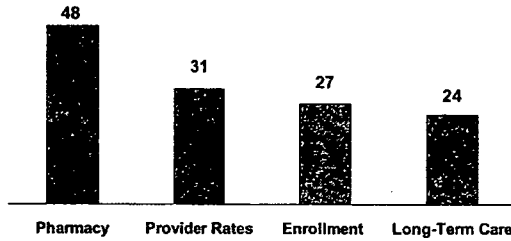
Source: CMS, Office of the Actuary, National Health Statistics Group, January 2002.

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Figure 18

### Top Reasons Reported by State Medicaid Officials for Medicaid Expenditure Growth in FY 2001

Number of States:

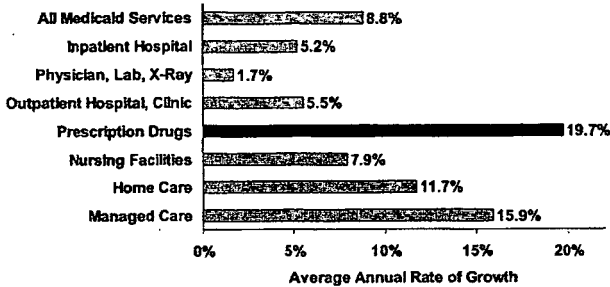


SOURCE: Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, June 2001.

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Figure 19

### Average Annual Rate of Growth in Selected Medicaid Expenditures, 1998-2000



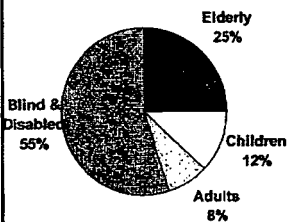
Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed (except for 'managed care,' which includes a wide range of medical services).  
Source: CMS, CMSO, Financial Management Reports (HCFA-64 data).

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Figure 20

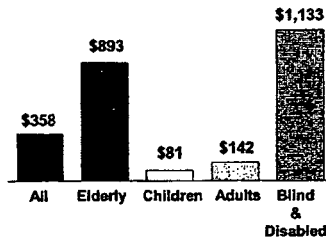
### Medicaid Prescription Drug Spending, 1998

#### Expenditures by Eligibility Group



Total = \$14.5 billion\*

#### Expenditures per Enrollee



\* 8.2% of total Medicaid spending on services. Includes both fee-for-service expenditures and estimated drug spending by managed care plans.  
SOURCE: Urban Institute Estimates, 2000.

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Senator CRAIG. Now, our last speaker on the first panel, Dr. Vernon Smith, who is currently a principal with Health Management Associates but also, as I mentioned, formerly Medicaid Director for the State of Michigan. He has done extensive work counseling States and others regarding Medicaid and related health, economics, and budgetary issues.

Doctor, thank you for being with us this morning.

**STATEMENT OF VERNON K. SMITH, PRINCIPAL, HEALTH MANAGEMENT ASSOCIATES, LANSING, MI; AND FORMER MEDICAID DIRECTOR, STATE OF MICHIGAN**

Mr. SMITH. Thank you, Mr. Chairman, members of the committee. I am very pleased to be here today to talk with you about the effects of the economic downturn on Medicaid and on the seniors and others whom the program serves.

Medicaid is of course a critically important program in the Nation's health care safety net for seniors and others on Medicare. Medicaid is extremely important, because Medicaid pays premiums, coinsurance, deductibles, for services, notably prescription drugs and long-term care, that Medicare does not cover.

Medicaid's role in supporting persons on Medicare has grown to the point where 35 percent of Medicaid spending is for persons also on Medicare.

Medicaid is now the largest health program in America, even larger than Medicare. In terms of the number of beneficiaries, this fiscal year, Medicaid will serve 44 million persons, and Medicare will serve 40 million persons.

In terms of expenditures, if my estimates are correct, this year, total Medicaid expenditures will be \$250 billion; for Medicare, a total of \$249 billion, and net of premium receipts, around \$227 billion.

The economic downturn has caused State revenues to take a nose dive just when Medicaid expenditures are skyrocketing. The State revenue outlook is not good at all. With the decrease in revenues this year at the State level, it would take an increase in State revenues of 8 or 9 percent in 2003 from this year for States just to achieve the same level of revenue in inflation-adjusted terms that they had 2 years before in 2001. This is extremely unlikely. In fact, States say they will be lowering their revenue forecasts still further this spring.

What this means is more pressure for across-the-board State budget cuts, and the current round of Medicaid cuts may be just the beginning. Already States have decided or are in the process of deciding to make major cuts in an effort to slow the growth in Medicaid spending. Examples abound across the country, and Barbara and others have described those already, in terms of cutting or freezing payment rates, cutting or restricting benefits, or cutting eligibility, in some cases, specifically, eligibility for persons with high medical bills who qualify under the medically needy category of Medicaid.

The current economic downturn has forced States to reduce Medicaid spending even if it means cutting services that have obvious value and even when the cutbacks have obvious adverse impacts on seniors and health care providers who serve them, and for States,

the frustrating thing is that the total spending cuts may be double or triple the general fund savings that are realized in order to make the budget reduction targets, because states must also cut federal matching funds.

When Medicaid was adopted by the U.S. Congress in 1965, no one expected Medicaid to become one of the largest programs in State budgets; no one expected Medicaid to allocate 35 percent of its spending to low-income Medicare beneficiaries, 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 seemingly have run out of strategies to control the growth in Medicaid spending. The prospect is that simple economics will put States under increasing pressure to scale back their programs. To the extent that that does occur, 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, I am very pleased to have the chance to talk with you about this and look forward to working with you. I am happy to answer any questions.

[The prepared statement of Mr. Smith follows:]

**Testimony of**  
**Vernon K. Smith, Ph.D.**  
**Principal**  
**Health Management Associates**  
**Lansing, Michigan**

**For the**  
**Special Committee on Aging**  
**The United States Senate**  
**Washington, D.C.**

**March 14, 2002**

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.<sup>1</sup>

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. In fact, most persons on Medicaid now are not receiving cash assistance from welfare.<sup>2</sup>

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.)<sup>3</sup>

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 billion, and Medicare expenditures (net of co-payments, premiums and third party collections) will be \$227.2 billion.<sup>4</sup>

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> Congressional Budget Office, January 2002 Baseline.



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

<b>Program</b>	<b>Fiscal Year 2001</b>	<b>Fiscal Year 2002</b>	<b>Fiscal Year 2003*</b>
<b>Number of Beneficiaries:</b>			
Medicaid	42.7 million	44.0 million	43.7 million
Medicare	39.5 million	40.0 million	40.0 million
<b>Expenditures:</b>			
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.<sup>5</sup>

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.<sup>6</sup>

<sup>5</sup> 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*.

<sup>6</sup> 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.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup>

**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

<sup>7</sup> Smith and Ellis, *Medicaid Budgets Under Stress*, 2001.

<sup>8</sup> National Conference of State Legislatures, 2001.

<sup>9</sup> 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.<sup>10</sup>

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%.<sup>11</sup>

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.<sup>12</sup> 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."<sup>13</sup>

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

<sup>10</sup> Mark Zandi, *The Outlook for State Tax Revenues*, Economy.com, February 2002.

<sup>11</sup> 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.

<sup>12</sup> National Association of State Budget Officers, *State Budgets - Update*, January 25, 2002.

<sup>13</sup> 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.<sup>14</sup>

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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<sup>14</sup> 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.<sup>15</sup> Examples abound, and have been widely reported in the popular press. Recent reports include:

- ξ 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)
- ξ 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

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<sup>15</sup> 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)

- ξ 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:<sup>16</sup>

**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.

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<sup>16</sup> 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"<sup>17</sup> 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.

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<sup>17</sup> National Governors Association, "State Efforts to Manage Medicaid Expenditures," February 2002.

Senator CRAIG. Doctor, thank you very much.

I do have some questions of all of you.

As you know, this committee is not an authorizing committee, it is an oversight committee. But we do believe that we play a valuable role with hearings like this and with testimony and the building of a record that clearly evidences the reality that we all face, both at the Federal level and at the State level. As health care progresses as rapidly as it has, and the costs occur, the programs that we are dealing with here are being rapidly outpaced. Then, of course, as you have mentioned, with economic downturns and States facing the reality of mandatory balanced budgets we run into some very difficult circumstances.

This question would probably be for you, Governor, and Director Kurtz. You described Idaho's recent and I think ambitious, plan to restrain Medicaid spending growth.

You have done this without fundamentally cutting core benefit eligibility other than prescription drugs; is that correct?

Mr. KURTZ. Mr. Chairman, that is correct. We have looked at coverage areas rather than eligibility.

Senator CRAIG. Do you believe that that is going to get you where you need to go?

Mr. KURTZ. Mr. Chairman, I do not think it will. As Dr. Smith said, our Medicaid program has been increasing about 15 percent a year. Our State revenues on a very good year increase 4.5 to 5 percent. So you have this gap, and to cut that gap, we need to look at how can we impact that line of increase, and we will have to look at eligibility as one of those criteria. Right now, our Medicaid program is right at the minimum in terms of our pregnant women and children programs, our CHIP program; our basic Medicaid program is at the minimum, so we are going to have to work with the Federal Government in terms of how do we impact those eligibility requirements.

Senator CRAIG. A few questions of you, Karl, and probably Gail. Some of these things States are doing in relation to cutting the benefit or at least payment to providers is short-term or might work. In the long term, providers begin to deny services simply because they cannot afford to provide them, and that ultimately comes about.

Overall, the analysis that we are going to have to have 8 or 9 percent annual increases in state revenues just to stay current with growing Medicaid costs. And yet, returning to such high revenue growth is just not going to happen under almost any estimate, although we might see substantial comeback in state revenues—Karl, you just mentioned the reality that even with a robust economy Idaho experienced, Medicaid was outpacing that, and to get back to that level will be quite an accomplishment by next fiscal year if we can get there.

I guess I am speaking generally but I would like all of you to comment on this difficult set of circumstances, and the reality that we are moving very slowly here as it relates to any form of Medicare prescription drug reform, although they do seem to be linked together in most policymakers' lexicon today here on Capitol Hill.

Dr. WILENSKY. I don't think the longer-term projections for Medicaid growth are double-digit; It is less than the 9.5 percent growth

that CBO is projecting next year. The growth may be faster than State revenues growth, but my understanding is that it is more in the 6 or 7 percent range.

Senator CRAIG. What is slowing that?

Dr. WILENSKY. For one thing, there is pressure not to use the upper payment limit, which has artificially increased spending—it was basically free money on the part of the State—and some of the benefit expansions that we had seen earlier are going to slow down; the increased payments. Some of the causes that increased were good spending in the late 1990's will not continue that is basically the rationale that the Congressional Budget Office is providing.

I think there are ways that States can slow down Medicaid spending by doing things better. The problem is that there are not quick fixes. In the 1990's, most States used managed care strategies for their acute care population and for a while slowed down the expenditures. They have run that gamut in my estimation, almost all of the States that could reasonably do that.

There has been less effective innovations in long-term care treatment. Arizona has tried to use managed care and other strategies in long-term care. You are going to hear from the Ohio aging director about some ideas that we were discussing that they are considering or doing in Ohio. The types of disease management programs that are sometimes being instituted for high-cost, high-volume diseases really do slow down spending. Health care spending, as you know, tends to be highly concentrated with relatively small numbers of people using very large volumes of dollars.

So there are some creative strategies. I am attracted to the long-term care partnering program which encourages middle-class individuals to buy insurance to protect their assets that are now counted in spend-down. This discourages attempts to distributing assets for people who realize they are going to have substantial long-term care needs.

None of them is going to be a silver bullet in the next year or two as States find themselves in a fiscal crunch, but they could allow for smarter spending over a longer period. But of course, there is the broader issue that was alluded to, which is whether Medicaid as we now know it really is the program for the 21st century in much the same way that people are asking whether Medicare as we now know it is the right program to accommodate the retirement of the baby boomers.

Those are difficult questions. These programs have provided important services for the populations they were intended to serve, but I think it is fair to say that what might have been sensible for 1965 might not make it for 2010.

Senator CRAIG. Thank you.

Dr. SMITH, you follow this, you discuss strategies, you advise States.

Mr. SMITH. The States face a very, very difficult prospect for the future. The long-term forecast for Medicaid expenditure growth from CBO through 2012 is 9 percent per year. There is no State that could possibly expect its revenues to continue to grow that rate.

Medicaid has continued to increase as a share of State expenditures whether you measure it in terms of general funds expendi-

tures or as total expenditures. The prospect is only that under the current financing structure, Medicaid will continue to take funds away from other worthwhile public purposes that are funded by State dollars, whether it be corrections, public health, education, or whatever.

That is not a good prospect, and it does suggest, as Gail indicated, that perhaps there needs to be some evaluation of the financing structure of the program, especially one where the program relies so critically on the availability and stability of State funding as the primary source of funding. All the important decisions about Medicaid programs are made by the States, and they depend on the availability of State revenues. The fundamental problem is whether States can sustain this program, which they believe in and want to support and have demonstrated their commitment to year after year by making appropriations even though it took money away from other worthwhile purposes. But even in the most optimistic of projections, the growth in Medicaid costs will far outstrip growth in State revenues.

Senator CRAIG. Let me add another question that you might want to respond to, and then I will turn to you, Barbara. Can we cut further without seriously risking further provider defections from the program?

Mr. SMITH. I think it is fair to say that every time Medicaid makes a cut, it does have consequences. It has consequences in terms of the health care services that States make available. Medicaid only pays for services which people need, and when you make cuts, whatever they may be, it has an effect on the people who are served by the program. It also has an effect on the providers who provide those services and have a commitment to serve the low-income populations.

I think it is inevitable that when States are forced to make cuts in provider payments—especially, as Gail pointed out, when Medicaid is already kind of the low-dollar payer—that that does have the effect of diminishing even further the pool of providers who are willing to serve and accept Medicaid as a source of payment.

So it is sometimes dramatic when you see a large group—in the newspapers in the last couple days, there has been some discussion about pharmacies possibly dropping out because of cuts in payment rates—but it is not just pharmacies, it is nursing homes, all of whom do not participate in Medicaid, hospitals, all of whom do not participate in Medicaid, doctors, dentists who do not participate in Medicaid. When Medicaid is forced to make these cuts as they inevitably will have to under the current structure, it will only further erode the participation of the providers.

Senator CRAIG. Thank you.

Dr. Lyons.

Dr. LYONS. Yes, I would concur with what Vernon has said. Thinking about the program, again, the majority of the spending in Medicaid is on elderly and disabled folks; these are people with serious, complicated, multiple health and long-term care needs. So any discussions of cutting the program could have very serious impacts on these populations who need access to health care services.

Medicaid is also an important source of Federal funds to the States, so I think that Vernon's testimony actually very clearly lays

out how much more money you lose by making a cut in State funding because you lose those Federal funds as well, and that money is very important to States' health care systems that serve elderly and disabled populations.

Thinking about the future, I do think there are short-term strategies which need to be considered which run the gamut from trying to achieve more cost-efficient care, but also looking at options to provide fiscal relief to the States, including raising the Federal match rate, increasing savings through the prescription drug rebate program, and providing some relief to States for senior prescription drug spending.

I think those are important things that could be done relatively quickly that would help States in the immediate timeframe. Longer-term, certainly there needs to be a broader discussion of whether there are better ways to provide care for these populations as we look toward the future. That could involve shifting responsibility from the States to the Federal Government for certain aspects of Medicaid.

But those discussions are complicated, they are hard, they affect States differently. They have implications for the State budgets as well as implications for the Federal budget and so require lots of discussion and debate to get to that point. But looking at the budgetary problems that we are facing and the aging of the population, these are discussions that we also need to engage in.

Senator CRAIG. Karl.

Mr. KURTZ. Yes, Mr. Chairman. In terms of looking at provider payments, I think that what we really need to look at coverage areas—do we cover a service rather than reducing provider payments—because the key element is that we have adequate providers and providing access to that care.

I think the other challenge we need to work on, and we are attempting to do, is getting our recipient enrollees engaged in their own health care, and making their own decisions around health care. That is one of the real encouragements I see in terms of our Children's Health Insurance Program, is working with those children—it is a long-term investment, as Gail said—but getting those children healthy and getting them educated about how do you become a good user of health care, so it is not a crisis, but it is health prevention and wellness. It is a long-term solution—it is not a quick fix—and some of us need some quick fixes.

We have a number of proposals from advocates, providers, and other groups for expanding Medicaid, and we have put a freeze on those. We are not going to be covering new services and/or new classes of people coming into the Medicaid program.

Senator CRAIG. Governor.

Dr. RIGGS. Thank you, Mr. Chairman.

On the reference to quick fix, I agree there are no quick fixes, because as I alluded to, I think the quick fix in the legislative process is just to cut reimbursement. I think the good news here is that I do believe there are greater efficiencies. There are ultimately better ways to do these programs. If there is some light at the end of the tunnel, hopefully, what we are being squeezed by right now will get us to be more innovative, because traditionally, we shift the budget here, do this and that.

I would point out what I would call the confusion of having Medicare, a program for those over 65, a medical program, and yet if you have particular financial liabilities or lack of funds, you also qualify for Medicaid. I think it is very confusing not only for providers but for the recipients to have this blending of programs. Then, of course, we get into the debate of whether it is the Federal responsibility or the State responsibility, so we have a blended—and a not very well-blended—program of which criteria do you meet.

I would say that it would be far simpler if you are over 65—or whatever the age should be—you have Medicare, and if you have means-testing, then you get the extended care services and so on, rather than forcing this distortion of two models that now overlap.

Let me add on the access issue that I do not think there is any question that as things get tighter, access also gets tighter. I would say that in Idaho, we have seen it, I have seen it. I have known of physicians who have always accepted Medicaid and Medicare who, with cuts in both programs, say it is to the point of being below the operation overhead cost, and they are just at a point—and we all know there is a nursing shortage now nationally—so those costs have actually gone up. You have forces that cannot co-exist, and something has got to give, and for some, it is access, just saying, “I just cannot afford to see Medicaid or Medicare patients any longer.” Senator Craig. Concluding thoughts by any of you? I will give you a minute.

Gail.

Dr. WILENSKY. You have hit on one of the biggest weakness in Medicaid, is the dual-eligible program. I agree with Lieutenant Governor Riggs that having Medicaid and Medicare overlapping programs is exceedingly expensive, is very clumsy, and does not provide the best source of care. I would very much rather have a Medicare program that had differential support for differing income levels so that people were on one program.

We need to decide whether Medicaid should continue as a Federal-State matching program. I thought the jig was up in the nineties because of provider taxes and donations. The foundation for cost control has been the State's share. States have indicated that when pressed, State share does not mean what the Feds think State share means. I believe we need to rethink the right program for the low-income population.

Finally, who gets to pay for long-term care. The proposals used to be that the Feds would take acute care, and the States would take long-term care. I was amused to notice in the last round of the National Governors' Association proposals, they proposed giving long-term care to the Feds, and they would take acute care. We clearly have not yet had a fulsome discussion about where long term care should be, who should control it, and who should pay.

Senator CRAIG. Concluding remarks from anyone else?

Dr. Smith.

Dr. SMITH. I would just like to build on what Gail said and what Lieutenant Governor Riggs also said in terms of the blending or the coordination between Medicare and Medicaid. I think this is really one of the key issues that needs to be looked at today. These two programs, established by the same Federal law, based on the



Social Security Act, should work together; but in fact they do not work so well together. There needs to be some effort, which would require some change in Federal law, in order to have these programs work in a coordinated way so they work together, and they work together for the good of the patients as well as the providers.

I would also suggest that there are some things just in terms of thinking about how to deal with the solution. Gail referenced who is responsible for what, but I think you could certainly build a case that the Federal Government has responsibility for the seniors, and that might in fact be a place where States could be provided some of the fiscal relief that they need if in fact the Federal Government were to assume the greater share of financing for the services that Medicaid provides to this group.

We do have a situation that needs to be looked at. When States have this shortage—I was just thinking about Idaho and the other 10 or so States that have Federal matching rates for Medicaid at around 70 percent—when the State budget dictates that cuts have to be made, States have to cut. In the case of Idaho and these other 10 States, to save \$1 million for State funds to apply to the shortage, you have to cut the budget by around \$3.5 million. And it is the \$3.5 million that has the impact on the providers and on the beneficiaries in those States. If there is some way that we can address that so that States can better finance the program, that would be good.

Senator CRAIG. We have just been joined by one of my colleagues and a member of the committee, Senator Carper, and I will turn to him, before we release you, for any opening comments he might have or questions of you.

Senator.

Senator CARPER. Thank you, Senator.

I want to welcome each of you. Thanks for joining us today. It is nice to see some of you again and to meet others for the first time. I understand one of you is from Idaho, and you might even know the Governor there, who used to serve here. I had the pleasure of serving with him when I was Governor of Delaware and a member of the National Governors' Association.

Would you give him a message for me?

Dr. RIGGS. Certainly.

Senator CARPER. I used to encourage him to consider at some point in time seeking the chairmanship of the National Governors' Association, which as you know rotates from Democrat to Republican. The current chairman is John Engler of Michigan, and succeeding him will be a Democrat, Paul Patton of Kentucky, and there will be a vacancy for the position of vice chairman, which will go to a Republican. Just tell your Governor that I cannot think of a better candidate than him.

Dr. RIGGS. I will relay that back.

Senator CARPER. I used to encourage him to do that; I said he was just made for the job. He will do a great job. Give him my best.

Dr. RIGGS. I will relay that message this evening.

Senator CARPER. Thanks very much.

I apologize for arriving a bit late. We have been holding a hearing over in the Commerce Committee, where I testified with respect to future passenger rail service for our country.

I am not going to ask each of you to repeat your testimony; I have a copy of it and will have a chance to review it later. What I will ask you to do is to take 30 seconds apiece, and say, if there is nothing else that the Senator from Delaware walks out of here with, I want him to keep this in mind. Just take 30 seconds. If he remembers noting else, this is what I would like him to keep in mind. I will just ask each of you to give me your best 30 seconds for the long haul, please.

Lieutenant Governor, do you want to take the first shot?

Dr. RIGGS. Certainly. I would say that with the coming "age wave," if we think we have problems now, we have no idea what a few years will hold for us. It is just time to do a redesign of both Medicare and Medicaid and really create some efficiency and look at the whole system and build a better model. It is time.

Senator CARPER. Thank you.

Mr. KURTZ. Senator, I am Karl Kurtz from Idaho. Looking at how we can get a handle around prescription drugs, the impact that seniors have on our Medicaid program in the area of prescription drugs, would be a take-home message; how do we as a partnership between Federal and State, our providers, and the clients that we serve build a better mousetrap in terms of prescription drugs.

Senator CARPER. Thank you.

Dr. WILENSKY. In the short time the States have to respond, they are probably going to respond by reducing provider payments. I think the biggest danger is for nursing homes, where Medicaid is the dominant payer. There is not a lot left there.

In the medium term, you can have better delivery of services. There are smarter ways through disease management and other kinds of programs, clinical protocols for the better use of new prescription drugs. But ultimately, we have to decide what Medicare should look like and what Medicaid should look like—Medicare for the baby boomers and Medicaid because it is not clear that the Federal-State partnership that was set up in the 1960's makes sense for the 21st century.

Senator CARPER. Thank you.

Ms. Lyons.

Ms. LYONS. Medicaid is an essential source of coverage for low-income seniors, families, and others with disabilities. As we try to deal with these current budget stresses, I think it is critical that we remember that if States are forced to cut back either by lowering provider payments or cutting eligibility, the needs do not go away; so it shifts those needs to families and to providers who do not get compensated adequately for providing care. So policy-makers need to address the financing of Medicaid to shore it up and strengthen it as the safety net program it has been for the past 35 years.

Senator CARPER. Thank you.

Mr. Smith.

Mr. SMITH. Medicaid has grown so fast over the last decade that it has become as large as Medicare, even larger in terms of the number of persons served—44 million compared to 40 million. The costs of the program have put stress on the States and their ability to continue to finance the program. As a result, they have had to undertake serious reductions in the program, and there needs to be

a review of the structural financing of the program if it is to be successful into the future as it has been in the past.

Senator CARPER. Last week, we voted by a fairly wide margin to pass an economic stimulus package and sent it to the President, which he has signed. I did not support it. I actually supported a more expensive package back in October, November, and December, but I thought March 8 was a little bit late. The package that we passed, I said to one of our reporters back in Delaware that if I were the Governor of a State right now, especially a State that was hurting for revenues, I would be having a heart attack; and if I were the budget director for a State that was having a tough time with revenues, I would be in intensive care, given the effects, specially for those States that piggyback on the Federal Tax Code, and given I think the very positive effect that the accelerated depreciation will have on business investment that we need, by the same token, it serves to undercut State tax revenues rather considerably in my State and I know in other States.

In earlier versions of the bill, we had an offset to help States particularly on the health side, but we could not work out a consensus there.

In Idaho or any other States that are represented here, how are you going to deal with the impact on your revenues and your mounting Medicaid costs?

Dr. RIGGS. You pose an excellent question, and I am not sure that we have an excellent answer. We pieced together our budget for this year—the legislature will probably adjourn tomorrow—and it is razor thin. We have gone to every available source of revenue that we had, the budget stabilization funds and those sorts of thing, and there just is not money sitting anywhere.

The only approach left for those who want more services, whether it be in this area or in education in Idaho, would be to raise taxes. Clearly, there is nowhere else to go. So it has been a challenge.

Again, you all know the state of the Federal budget just a year ago; to see such a drastic change in 12 months has been truly remarkable, and it has been a challenge. That is why my sense is that we are going to squeak by right now, but with the problems that we see looming in the very near future, we will not be able to get by because of the number of elderly that are going to be coming into the system. It will not work.

Senator CARPER. Other comments?

Mr. KURTZ. Looking specifically at the impact on our State revenues, there are estimates between \$25 and \$75 million over the 3-year period. In a State where we only generate a little over \$1.9 billion in tax revenues anyway, that is a significant item. We were haggling between the departments and the legislature about \$1 million quite often; so a \$25 million swing is a significant point of discussion.

Senator CARPER. I am sure it is.

Lieutenant Governor, go ahead.

Dr. RIGGS. If I could add—and this was part of my testimony before you arrived—my fundamental belief is that whatever system we have, it is the economy through our tax structure that creates the revenues for whatever the system is.

So that most fundamentally, I believe that whatever we can do to keep the economy strong is very, very critically important. I see obviously the relationship that—

Senator CARPER. Yes. Unless you have a strong economy and the jobs and revenue that flow from that, you do not have much. I understand that in Delaware, and clearly you do in Idaho.

It is good to see you all. Thank you very much for joining us today and for your testimony.

Senator CRAIG. Let me thank the first panel for being here and for your contribution. We greatly appreciate it.

Thank you.

Let me ask our second and final panel to come forward, please.

Thank you both for being here. Our second panel this morning will focus on senior services programs. We will hear from Joan Lawrence, Director, Ohio Department of Aging, and Barry Donenfeld, Executive Director, Mid-Willamette Valley Senior Services Agency, as well as the current President of the National Association of Area Agencies on Aging. We thank you both for being here.

Joan, please proceed.

#### **STATEMENT OF JOAN W. LAWRENCE, DIRECTOR, OHIO DEPARTMENT OF AGING, COLUMBUS, OH**

Ms. LAWRENCE. Thank you, Mr. Chairman. I appreciate the opportunity to appear before this committee, whom we in the aging network count on for the kind of oversight you do and the ideas that you generate.

We are glad you chose Ohio to be part of the panel. We think we are really representative of the Nation in many ways. We are very diverse—we are rich, we are poor, we are urban, we are rural; and I think something that a lot of people do not know is that one-third of our counties are Appalachian, so we have a significant number of problems that accrue to being in that area.

I am Director of a Cabinet-level agency, but I am not the Medicaid agency. We have a contract with the Medicaid agency for our home health program. It represents nearly two-thirds of our budget at this time, and it is fast-growing—or, it was fast-growing, at least. We were serving 25,000 nursing home-eligible seniors. That may change a bit with the funding changes.

Our funding in the department is basically 58 percent Federal, 42 percent State, and at the local level, 51 of our 88 counties have senior levies of some kind to enhance services.

I am hitting my 71st birthday this year, so I am one of those seniors who is healthy and generally enjoying life, but I am here today to represent the others who are not.

I was glad—no one picked up on it in Lieutenant Governor Riggs' testimony—he referred to a proposal to change the way we look at seniors in Medicare to a group called "pre-seniors" who are 65 to 75. I like that.

Senator CRAIG. I am soon going to like that also.

Ms. LAWRENCE. Well, there is a lot of truth to it, too, and we should look at the populations differently. Eighty-five and over is where the problem really hits home the most.

The economic downturn has had a significant effect on Ohio's seniors. We have had, as has everyone else, shrinking personal income and sales tax revenues. Before the budget was even cold, in addition to a 1.5 percent cut we made through the budget process, another 6 percent cut. For the first time in some time, our in-home health program, which we call Passport, was affected. Normally, we have been protected from those cuts. The 6 percent cut produced waiting lists immediately. It was drastic—going from 700 per month enrollment to 500—and managing that enrollment is very difficult. In just 2 months, we had over 1,000 on the waiting list, and of that 1,000, 15 percent, or 150, entered nursing homes directly.

Interestingly, we are going to be able to demonstrate to the Governor—and I hope it will do some good—that the amount of general revenue we saved in our home health program is going to be equal to the amount we spend on the increased nursing home placement, even though it is only 15 percent. So I am hoping that that might make a difference in the future.

It is compromising our ability to implement the Olmstead decision and will continue to do so. Our waiver cost is about \$11,200 including administration. Nursing home average is \$52,000. So the difference in cost is quite significant. Here is where we come to you. Part of the problem is that the Medicaid program is biased and has been since it was created toward institutionalization. Medicaid will pay—it is an entitlement—if you are Medicaid-eligible, nursing home-eligible, Medicaid pays, there is no question about it.

There are cheaper alternatives to nursing home placement, but because Medicaid does not pay for it—it does not pay for room and board, does not pay for other services—we cannot use that opportunity for some of our clients.

The Governor is very eager to implement our report on "Ohio Access for Persons with Disabilities" and is severely limited in doing so because of the way we fund these services.

We are hoping that some of that will change. I talked to someone recently who is working with getting people out of nursing homes who could live at home if they had the ability to have the money follow them. She has 25 people waiting, and she is struggling to find housing and other services.

We even have a waiver in our State budget to allow 200 people to get some extra money so they can move out of nursing homes if they are able to, with health and safety, and we can hardly find 200 because the funding to pay for the housing is just simply not there.

I thought—and I feel like I want to say it because at this point, no one has mentioned it—Illinois just recently got a waiver from CMS for prescription drug coverage, and CMS did something that I think is very helpful. They said that if any other State wants to follow exactly what Illinois proposed, they could do it without going through the waiver process. I think that is a step in the right direction, and I hope they will continue along that track.

I have several examples of how senior services have been affected—I will let you read them—but one thing that really surprised us was that the waiting lists for home-delivered meals have doubled in some areas of the State just in the recent period of time.

So what we suggest to you in general is that we should help people help themselves. Most long-term care is done by friends, neighbors, family, as you know, and I think Congress can be very, very proud of the National Caregiver Support Program that was enacted with the reauthorization of the Older Americans Act. It is making a big difference. I think you are going to see good results. It really does help people who are doing all the work.

We have to give people real choice in long-term care. That is a real challenge for you, and you have heard that you really do have to look at Medicare and Medicaid together—you just do. When I hear our Medicaid director suggest that a program does not make any difference in Ohio because it saves Medicare money—that it does not save Medicaid anything—that is something I think we need to somehow nip in the bud.

We have to support people in their efforts to plan for long-term care. We just put on the web last week a Long-Term Care Consumer Guide that incorporates not only the regulatory information and the basic facts about nursing homes—all of them—but includes for the first time family satisfaction surveys, and it will include by the end of the summer resident satisfaction surveys; we are in the process of doing those now.

Finally, I will just agree with everyone else about prescription drugs. It would be a critical place to start. The Governor is trying to get a drug discount card in place through the legislature, a little different from what the President is proposing, and we are having trouble. The pharmacists claim it will drive them out of business and similar things that you have probably heard.

So the effort goes on in Ohio and in the rest of the Nation, and I thank you for listening.

Senator CRAIG. Joan, thank you very much.

[The prepared statement of Ms. Lawrence follows:]

ODA0003

# Ohio Department of Aging

50 West Broad Street/9<sup>th</sup> Floor, Columbus, Ohio 43215-3363  
(614)466-5500 TTY (614)466-6191 FAX (614)466-5741



Bob Taft, Governor  
Joan W. Lawrence, Director

**Testimony Presented by Ohio Department of Aging  
Director Joan W. Lawrence  
The United States Senate  
Special Committee on Aging  
March 14, 2002  
9:30 a.m.**

## **Opening Introduction**

Thank you Mr. Chairman, Ranking Member and other members of the Senate Special Committee on Aging, for the rare opportunity to testify before this important and prestigious committee. Let me begin by acknowledging the committee's wisdom in selecting Ohio as a focal point and reference point. I say that because Ohio truly represents the nation.

## **Ohio Background**

With 12 million citizens concentrated in America's Heartland, Ohio reflects America in every way - in diversity of race, of culture, of religion and of every demographic and economic variable. We are urban and we are rural. We are rich and we are poor. Our four largest cities rank among the top 50 most populated in the nation. Several others rank in the top 100. All reflect the strengths and weaknesses of America's cities. Our capital city, Columbus, has grown in recent years to be our largest. It boasts a diverse economy, broad-based, but relatively free of heavy industry. Our 88 counties have deep agrarian roots and maintain economies based on a mix of agriculture and industry, represented by large and small business in both service and manufacturing sectors.

One third of our state's 88 counties are within the Appalachian Region. Poorly developed transportation resources and other infrastructure necessary for economic development make this area as difficult to serve as any in the nation. In all, Ohio represents just five percent of the nation's total population, but 100 percent of the nation's fabric. The committee chose well selecting Ohio. We are truly a state of two halves. Today's topic, "The Economic Downturn & Its Impact on Seniors" is very much about the haves and the have-nots.

### **Agency and Personal Background**

As Director of the Ohio Department of Aging, I head a cabinet level agency with an annual budget in excess of \$320 million. Nearly two thirds of our total budget fuels our popular Medicaid Waiver program which provides home care services to nearly 25,000 nursing home eligible seniors. The Ohio Department of Aging provides programmatic leadership and fiscal monitoring of the aging service delivery system comprised of 12 Area Agencies on Aging.

Each provides senior services to a multi-county area, contracting with local providers--many of which are senior centers--to provide essential services like transportation, congregate and home-delivered meals, home care, legal counsel, ombudsman and protective services, etc. Our funding is roughly 58 percent federal and 42 percent state funds. Local funding is in place in 51 of Ohio's 88 counties through property tax levies.

In addition to leading Ohio's aging network, I will celebrate my 71st birthday this year as one of nearly two million Ohio senior citizens. I personally represent the half of Ohio Senior Citizens enjoying reasonable health and personal wealth. But I am here today to speak on behalf of the less fortunate half.

I am a career advocate and activist. I served 16 years in the Ohio House of Representatives after many years as a professional volunteer and activist in the Ohio League of Women Voters. In the Ohio House, I represented a district reflective of the two Ohios, two distinct and very different counties. One was the fastest growing and most prosperous county in the state and indeed the nation; the other exhibiting all the features of Appalachia, Ohio's poorer half. My tenure spanned the difficult economic climate during the early 1980s and most of the high flying 1990s. During the late 1990s I was lead sponsor of welfare reform in Ohio, both before and after Congress acted in its reform efforts. I've been called "The Mother of Welfare Reform in Ohio" - and worse. So I come today prepared to discuss the haves and the have-nots with the experience and perspective to know the power of the cans vs. the cannots.

### **Major Effect of Economic Downturn - Loss of PASSPORT Funding**

The economic downturn has had a dramatic effect on services to Ohio seniors. As you know, all states operate on balanced budgets. This State Fiscal Year, shrinking personal income and sales tax receipts forced an immediate cutback of 6 percent to general revenue funding. The result? A chilling effect on PASSPORT, the state's popular Medicaid waiver program that provides home-based health care and personal care services to nearly 25,000 nursing home eligible seniors.



Waiting lists formed almost immediately with the loss of more than \$3.6 million in state funding and the consequential loss of an additional \$6 million in federal Medicaid reimbursement. The economic loss to the service network and the emotional toll on seniors who rely on home care services has been devastating. Traditional referral sources like hospital discharge planners are today less likely to refer to the program. Instead, eligible would-be participants are entering nursing homes—the much costlier alternative—at an alarming rate. Nursing homes are the only alternative available to eligible seniors. In the bargain, Ohio's ability to comply with the Olmstead Decision is greatly compromised. In Ohio today, there is no choice in long-term care for the poor.

This open avenue is a direct route to further fiscal disaster. Because nursing homes cost four times as much as home care, the painful truth is that every dollar "saved" by cuts to the Medicaid waiver program has a potential cost of \$4, because the waiver program's average annual cost is \$11,200; the nursing home average is \$52,000.

It is clear in Ohio's experience that the bias toward institutional care that has existed in Ohio for three decades is long overdue for change. In Ohio, there exists no true spectrum of services, even though Ohio Governor Bob Taft has recommended that there be such a spectrum of services in a report issued in 2001 called Ohio Access for Persons with Disabilities. While the Taft Administration wants to fully fund PASSPORT, the federal institutional bias is more exacerbated in Ohio because nursing home rates are locked in state statute. With few exceptions, Medicaid eligible Ohioans have only two choices, and with PASSPORT home care waiting lists, today there is only one choice—care in a nursing home.

Governor Taft's vision is to provide people community options they prefer—options that enable dignity and real choice. People need and deserve meaningful choice in long-term care. For the poor, Ohio's PASSPORT Program provides choice at a fraction of the cost of nursing home care, but it is the very program forced to be cut in the state budget. Nursing homes remain protected from state budget cutbacks. Ironically, home care is the choice people prefer, and at a price that saves taxpayers millions per day. It could save billions more.

The states can tell you the effects of the downturn in graphic detail through heart wrenching personal stories and through rigorous review of outcome-based strategies.

States know what innovative approaches provide the most efficient and cost effective benefits. Most have experience with best practices that provide real assistance and what people really need.

But beyond the Medicaid Waiver program, its need for expansion and the need for choice, what is the state of the state in Ohio currently as a result of the economic recession? Let's review a sampling of comments from the hinterlands:

- ξ The Youngstown Area Agency on Aging reports the loss of 6,000 jobs as steel plants close. Loss of pensions and health benefits do not bode well for aging workers.
- ξ Statewide, nutrition sites report a tenfold increase in waiting lists for home delivered meals; a doubling in waiting lists for congregate meals.
- ξ Food banks throughout Ohio are reporting increased traffic—some as high as 96 percent.
- ξ Demand for senior employment services has doubled. There has been a 50 percent increase in attendance at senior job fairs.
- ξ At the same time, demand for senior employees has fallen dramatically. Contractors with Senior Community Services Employment Program (SCSEP) are working more closely with one-stop job centers even during a time when the Department of Labor hasn't figured how to deal with the distribution of additional dollars resulting from the reauthorization of the Older Americans Act. Layoffs of younger workers have triggered greater competition for available jobs. SCSEP contractors are offering skill training to help older workers compete. Training includes computer literacy. One novel project is using information technology to allow older workers in rural areas to work for companies out of their homes, utilizing computers.
- ξ Agency Directors fear support for local levies will wane along with the value of assets upon which the levies are based. More than half of Ohio's 88 counties have such levies and many are up for renewal.
- ξ The Ohio Attorney General's Office reports a 60 percent increase in restitution orders resulting from Medicaid Fraud. Convictions for abuse are up by roughly the same percentage.
- ξ Ombudsman complaints of financial exploitation by family (not against facility) rose 75 percent from last year.
- ξ During uncertain times, fear is heightened as elders are reminded of depression losses. One caseworker recounted the story of a woman whose 61-year-old son had become distant and preoccupied with his own job search just when she needed him most. The client is needing help in decision making and concrete assistance moving to assisted living from her home of 57 years.

Her son is so stressed about his job loss and loss of benefits that he is increasingly unavailable to her. This is increasing her worry and stress. Lots of intergenerational issues.

Ohio's experience yields three major themes:

#### **Help People Help Themselves.**

Fully 80 percent of long-term care services is provided by the informal caregiver network of family and friends—not Medicaid or government services. A recent Alzheimer Association study places an \$8 billion value on the care provided in Ohio alone. That's more than Ohio's total Medicaid budget. All levels of government should provide support to this network of informal caregivers. Congress can take great pride in its creation of the National Caregiver Support Program, a major enhancement to the Older Americans Act. Please know that the additional funding provided during the reauthorization of the Older Americans Act is making a difference in Ohio. Throughout Ohio, a strong consortium of associations is forming to provide educational and emotional support to families and respite care is growing along with this support.

#### **Give People Real Choice in Long Term Care**

Ohio and many other states have demonstrated the success of Medicaid Waiver programs like PASSPORT, providing home care to thousands of people at a fraction of the cost of traditional nursing home care. Expansion of such programs is part of the answer. We must all "Do the Math!" Medicaid Waiver programs save billions. An institutional bias of funding long-term care means access to affordable in-home care is severely limited. Families don't have a full range of choices unless they are wealthy enough to pay for them out of pocket. All but a very limited amount of Ohio Medicaid funds that are devoted to long-term care go to nursing homes. This institutional bias in our funding-driven system has resulted in a patchwork quilt stitched together with county levies rather than a comprehensive program that provides the best choices for families.

#### **Support Efforts to Help People Plan for Long Term Care**

States need to encourage programs that help people take personal responsibility for their own futures. Ohio promotes free personal in-home assessments to help families determine their future needs, based on a review of their own resources and their eligibility for senior programming and other assistance. In Ohio, we provide long-term care planning assistance through an on-line tool called Benefits Eligibility Screening Service (BESS). BESS was the forerunner and pilot to the newly launched national computer planning program, Benefits CheckUp, sponsored by the National Council on Aging.

Last week, we launched the Long-term Care Consumer Guide, the first Internet-based guide that incorporates detailed customer satisfaction surveys of both residents and their families alongside other pertinent information from regulatory agencies and facilities themselves. It is innovations and projects like these that will empower citizens to take their futures in hand and control their personal destinies.

Finally, a recent survey of 60,000 seniors found that prescription drug costs was the most serious concern of more than half of respondents.

Ohio Governor Bob Taft has taken up this issue of prescription drug costs, proposing a bill that would add a prescription drug discount benefit to an existing merchant/member driven discount program called the Golden Buckeye card. Legislation passed by a nearly unanimous vote in the Ohio House of Representative in June of 2001. It remains stalled in the Senate, held hostage by a small cadre of senators reluctant to release a profit margin their constituent pharmacists cling to in the life and death struggle between the haves and the have-nots. Mr. Chairman, Ranking Member and other members of the Senate Special Committee on Aging--the saga continues--in Ohio, and in the nation.

Thank you.

Senator CRAIG. Now let us turn to Barry Donenfeld, Executive Director, Mid-Willamette Valley Senior Services Agency, and currently President of the National Association of Area Agencies on Aging.

Thank you, Barry.

**STATEMENT OF BARRY DONENFELD, EXECUTIVE DIRECTOR, MID-WILLAMETTE VALLEY SENIOR SERVICES AGENCY, AND PRESIDENT, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, SALEM, OR**

Mr. DONENFELD. Thank you, Senator.

Ranking member Senator Craig, Senator Carper, good morning. I am pleased and honored to be able to visit with you for a few minutes this morning.

I am the Area Agency on Aging Director for Marion, Polk, and Yamhill Counties in Northwest Oregon. My testimony today will have three parts—sharing with you from NAAAA's national perspective some reflections on the difficulties older persons are having due to the economic downturn; briefly describing Oregon's community-based approach to long-term care; and discussing some innovative and cost-effective ways that our agency has stretched limited resources, improved and enhanced services, and prepared for the future.

As I discuss these different topics, I will try to just touch on important themes and refer you to my detailed written testimony for lots more information and lots of statistics.

I will start with information gathered by NAAAA. AAAs typically serve older women having difficulties with daily tasks like bathing, eating, and dressing. AAAs throughout the country report that they are working more and more with vulnerable and hard-to-teach individuals as well as persons with disabilities.

For the last year and a half, NAAAA has heard repeatedly from AAA directors through the country that things are tough and that seniors are needier than ever. The economic downturn is definitely affecting older people. Here are a few anecdotal snapshots from around the country.

New York City—and I would like to qualify this by saying that very little of this is related to the events of September 11; these events were in play prior to those horrible events—New York City has a \$36 million cut to their Department of Aging. To absorb those budget cuts, they are eliminating weekend meals, they are shutting down seven senior centers, they are eliminating plans to build four new senior centers, they are eliminating service contracts, and they are reducing all of their contracts across the board.

In Alabama, it has been reported that there is a 50 to 75 percent increase in requests by seniors for employment assistance, with the greatest increase occurring since August of last year.

My home State of Oregon has been hit hard as well. We have the highest unemployment rate in the country, and we are not recovering yet. At my agency, we have experienced a projected 20 percent annual growth rate in requests for public assistance. Our local utility companies report between a 16 and 37 percent increase from this same time last year in requests for payment assistance, and

many of the individuals requesting such assistance are in fact seniors.

My State of Oregon has a reputation for long-term care innovation. Most of that results from listening to our older residents and realizing from our own experience that nursing homes cost four times more than community-based care. I talk to lots of seniors, as I am sure the distinguished Senators do. I have never heard a senior say to me—and you probably never have, either—"I want to go to a nursing home." It simply does not happen.

Using Federal Medicaid waivers, Oregon has figured out a way to minimize nursing home placements while maximizing community-based options. We save lots of money, and we use it to serve lots more people in the ways that they want to be served.

We are the only State in the country that has fewer people in expensive nursing home care than we did 20 years ago. The Oregon long-term care system serves seniors and people with disabilities with a one-stop shopping approach. Most of the system is administered through local AAAs like my own, whose staff serve as navigators and gatekeepers.

Also, as we developed options for Medicaid clients, these choices became available for older adults and people with disabilities who are not eligible for Medicaid, allowing them to stretch their personal resources further and delay or eliminate reliance on public resources.

A final part of my testimony today will focus on ways in which our agency has strategically viewed threats such as funding decreases and other challenges such as demographics as opportunities for innovation and creativity.

Oregon is graying faster than most States. People 85 and older are the fastest-growing age group in our State. They will double in 20 years. Nearly one in five is low-income, and 50 percent have significant long-term care needs. As this group ages and the boomers join them, the demands and pressures, as you have heard from previous witnesses, on the long-term care system will be staggering.

At our agency, we have taken a variety of actions to respond to these pressures. We have developed lease-purchase arrangements that will allow us to own two buildings and land after 15 years. For both buildings, planning began with feasibility studies that revealed that the cost of purchasing an operating space would actually cost less than continuing to lease commercial space. In 15 years, when we are no longer paying rent, we will have \$500,000 a year to plow back into our programs.

Ten years ago, we began an innovative way of stretching limited Title III-C nutrition funds by developing a seven-county partnership with two other AAAs, Oregon Cascades West and Lane Council of Governments. Currently, this partnership provides 650,000 meals a year to about 11,000 seniors in 32 communities. The economy of scale created immediate financial rewards for all three agencies. The initial rate for the meals was down 12 percent. Today, 10 years later, we pay 69 cents less per meal than if the consolidation had not occurred. During this project, the three programs have realized a savings in excess of \$1.8 million—a lot of money in a small State like Oregon.

If all we had done was save money, this consortium approach to Older Americans Act nutrition services would have been a big success. But we were not only able to cut costs but also to improve and enhance the actual meals service through the reinvestment of savings. We started a dual-entree system, including one "heart-healthy" choice per day. We have a high-quality program featuring from-scratch cooking tailored to the tastes of Northwest seniors, and we started a frozen meal program that provides weekend meals, serves rural communities too small for a meal site, and gets homebound meals to geographically isolated individuals.

Since this frozen meal program began in 1996, it has grown by nearly 62 percent, all paid for with savings from the reinvention of how we contract for the noon lunch program.

Building upon the successful food service consortium, we are jointly contracting for in-home services with the same partners. We do not expect to leverage the same type of savings as the food project, but we have already stabilized costs and made sure that we are always likely to have a stable in-home services contractor in place.

Thank you for the opportunity to share this information with you. I hope I have offered you some suggestions that can be replicated in other parts of the country. I look forward to answering your questions.

[The prepared statement of Mr. Donenfeld follows:]

**Testimony of  
Barry Donenfeld, Executive Director  
Mid-Willamette Valley Senior Services Agency, Salem, OR  
and  
President, National Association of Area Agencies on Aging**

**Before the Senate Special Committee on Aging  
The Economic Downturn and Its Impact on Seniors:  
Stretching Limited Dollars in Medicaid, Health and Senior Services**

**March 14, 2002**

Good morning, Ranking Member Craig, Chairman Breaux and distinguished Members of the Senate Special Committee on Aging. My name is Barry Donenfeld, and I've been the Executive Director of Mid-Willamette Valley Senior Services Agency (MWVSSA) since 1990. I'm also the current president of the National Association of Area Agencies on Aging (n4a). Mid-Willamette Valley Senior Services Agency is the Area Agency on Aging (AAA) that serves Oregon's older adults in Marion, Polk and Yamhill counties in northwest Oregon. I appreciate the opportunity to share information about MWVSSA, n4a, Oregon's long-term-care system and the cost-effective ways our agency has been able to provide services.

For the last year and a half, n4a has heard repeatedly from AAA directors all across the country how shrinking state budgets, increased demand for services and local fiscal constraints are impacting their agencies' ability to serve vulnerable older people.

The fundamental mission of n4a and the AAAs is to help older Americans stay in their own homes and communities with maximum dignity and independence for as long as possible. AAAs are dedicated to enhancing the quality of life for older Americans and their families by providing information about and access to a variety of services in local communities. AAAs often serve as a "single point of information" for the complex and fragmented range of home and community-based services for older adults and their caregivers. These services include congregate and home-delivered meals, other in-home services for frail seniors (such as personal care and chore services), elder abuse prevention and protections, the nursing home ombudsman program, senior centers, transportation, consumer information, education, counseling and senior employment.

The strength of the AAA system is that it's a nationwide network of agencies that share a common mission and provide a set of core services. Since the mid-1970s, AAAs have demonstrated an extraordinary record of achievement in stretching a limited amount of federal money to help hundreds of thousands of older people avoid costly nursing home placement and to remain independent in their communities. Older Americans Act (OAA) funds make it possible for AAAs to leverage millions of non-federal dollars from local governments, foundations, the private sector, program participants and volunteer contributions. The OAA is a prime example of federal, state, and local partnerships that work.



Mid-Willamette Valley Senior Services Agency is one of 18 AAAs in Oregon. All Oregon AAAs administer programs funded through the federal Older Americans Act and a state program, Oregon Project Independence (OPI). Some Oregon AAAs, like MWVSSA, also administer Medicaid long-term-care programs for the elderly. A few AAAs provide these services to younger adults with disabilities as well as older adults.

The mission statement of MWVSSA, is "to assist older persons in making and implementing choices that increase independence and quality of life." MWVSSA is the second largest AAA in the state, with a current caseload of about 5,300 individuals and an annual budget of about \$53 million, which includes service payments of \$43 million. The agency employs 135 individuals at its five offices and 12 meal sites.<sup>1</sup>

The agency was created in 1982 to serve older adults in Marion, Polk and Yamhill counties. The nine County Commissioners from this tri-county area serve as the agency's Board of Directors and are actively involved in setting policies for the agency's operations. MWVSSA is particularly proud of its active, involved 23-member Advisory Council that admirably fills the council's role under the guidelines of the Older Americans Act.

### **The Current Economy**

#### **Oregon**

The current economic downturn and how it could affect MWVSSA's ability to deliver services to older adults has concerned our staff, advocates and clients. In the past two months, Oregon's Legislature has struggled through special sessions to rebalance the state's budget and erase an \$846-million revenue shortfall in the state's two-year, \$12.3 billion budget.<sup>2</sup> While the overall unemployment rate for the nation fell to 5.6 percent, Oregon had a seasonally adjusted unemployment rate that rose to 8.0 percent in January.<sup>3</sup> Though other states may be seeing signs of economic recovery, Oregon is not.

For example, Mid-Willamette Valley Senior Services Agency realized a five percent increase in clients receiving public assistance, specifically food stamps, from October through December, 2001.<sup>4</sup> If this trend were to continue, it would represent a 20% annual growth rate.

In addition, advocates for Oregon's senior services programs have been concerned that in their effort to rebalance the state's budget, the Oregon Legislature might make cuts that restrict Oregon's cost-effective, community-based model for delivering long-term-care services to seniors.

#### **National**

Oregon is not alone in its concerns about the effect of the economy on the AAAs' ability to provide assistance to all older adults in need of vital social services that allow them to remain in their homes and communities. Over the last few years, many AAAs across the country have been

affected by tightening state budgets. The recent downturn in the national economy has only aggravated the effect. Several states have reported that they are prioritizing the services they will provide and trying to safeguard the most frail and vulnerable service recipients.

Metropolitan areas are feeling the squeeze between an increased demand for services and diminished fiscal capacity. The New York City Department on Aging received a \$12.3 million budget cut in November, 2001, and just recently received an additional \$26 million, or 16 percent cut, to their budget. The Department worked diligently to maintain core services for the millions of seniors it serves. However, to absorb the budget cuts, the Department has proposed eliminating a recently-implemented weekend meal provision and consolidating other services. The proposal includes shutting down seven senior centers, eliminating plans to build four new senior centers, eliminating funding for particular senior program contracts, and implementing an across the board 2 percent reduction in all senior service contracts.

Rural counties have been hit especially hard by the economic downturn. According to a recent article in *The Public Policy Aging Report*, Fall 2001, the trend of out-migration of the younger population has resulted in eroding tax bases, inadequate labor pools, and increased numbers of uninsured. Rural counties, particularly those not adjacent to metropolitan areas, often have more than a fifth of their population over 65 years of age, with a higher than average percentage of these elders being 85 years and older. Age and poverty each result in higher demands for social services, but together the need is significantly exaggerated. Rural communities tend to have a higher percentage of persons living in poverty, with the rate approaching 50 percent in some states and among some groups of older adults. For example, a southern Ohio AAA serving 10 rural Appalachian counties, just had the majority of these counties go from labeled "at risk" to qualifying as "in distress" based on low per capita income and high poverty and unemployment.

Numerous rural AAA directors assert that transportation is one of their most difficult problems. Increased gasoline costs have negatively affected both older adults in need of services and the service providers themselves. A director of an upstate New York AAA said her agency has seen a significant increase in the demand for trips in the last year and attributes the increase to the fact that many older adults could no longer afford their automobiles. Because they can't get to services, rural older adults need the services to come to them. A central Oklahoma AAA recently reported that, while the demand for home-delivered meals continues to increase, the ability of the agency to provide the volume of meals needed has been reduced due to high gasoline prices, increases in insurance and other transportation costs.

Older adults have, like the nation as a whole, felt the impact of the downturn in the stock market, low-interest rates and an increase in unemployment resulting in a reduction of disposable income. AAAs have indicated a significant increase in the number of older adults seeking participation in senior employment programs within the last year. For an Alabama AAA, there has been a reported 50 to 75 percent increase in requests for employment assistance at the senior

employment program they operated during the last year, with the greatest increases occurring after August. Their waiting list is so great that the AAA has had to direct seniors to the county employment program, an agency which is also experiencing a similar overload.

**The Oregon Long-Term-Care Model:  
Lower Cost, Community-Based Care for Most Medicaid Clients**

According to legislative testimony presented for Oregon's Department of Human Services, in 1985-86, six of every 10 Medicaid clients lived in a nursing facility. By 2000, as a result of Oregon's long-term-care options, only 2.8 of every 10 Medicaid clients were residents of a nursing facility. The Oregon model for long-term-care is nationally recognized for the cost effective way it delivers services and for the emphasis it places on helping older adults and people with disabilities stay where they almost always want to stay, in their own homes and communities. The Oregon model builds on the Older Americans Act values and establishes one-stop, integrated, community-based programs that provide unique opportunities for older Americans and their families.

This model utilizes a combination of state and federal funds in the delivery of community-based programs. Since state funds are matched by federal funds (at almost \$2 of federal funds for every \$1 of state funds), it requires adequate funding from both state and federal sources to maintain services.<sup>5</sup>

**History**

The Oregon system for long-term-care was created by the 1981 Oregon Legislature in response to advocacy efforts by Oregon seniors and in response to a major recession that faced state government. In the late 1970s and early 1980s, the state was in a recession due to a significant downturn in its major industry, the wood products industry. The state was also experiencing increased costs in nursing facility expenditures.<sup>6</sup>

From 1974 to 1979, the state estimated that Oregon's nursing facility caseload increased more than 30 percent, while the population of Oregonians aged 75 and older was growing only by 14 percent. The rate of inflation in nursing facility cost was over 100 percent, while medical inflation was about 80 percent. To cut costs, the 1981 Oregon Legislature developed a new Senior Services Division. The new division was directed to contain long-term-care costs while ensuring that services offered clients independence, dignity, privacy and choice.<sup>7</sup> I offer this information as other states can look to the Oregon model as a way to cut costs and/or expand services through reinvestment of savings in their own states.

Oregon's new division was able to develop a community-based-care system by securing a Title XIX federal waiver that allows the state to spend Medicaid nursing-facility dollars on less costly and more desirable community-based care. The savings from nursing-home care was used to develop a network of care options that include the following:<sup>8</sup>

## **Oregon's Long Term Care Choices**

### **In-home Services**

In-home services are the most rapidly growing and the most popular part of Oregon's long-term-care system. Seniors and people with disabilities can receive services in their own homes or apartments. Those services include help with personal or health care needs and may include help with housekeeping. In-home services can include: meal preparation, shopping and transportation, home health services, assistance with medications, housekeeping and laundry services, money management, assistance with medical equipment and help with dressing or personal hygiene. Nursing services and home-delivered meals can also be arranged. Clients can choose their own caregivers or the agency can arrange for their care.

A client-employed-provider program allows providers to work directly for the person receiving care, so the clients can control and direct their own care services. These providers are screened for criminal record histories by the state and hired by the client. There are about 13,000 client-employed-providers working in Oregon. The state also has an estimated 1,800 adult foster homes, over 150 nursing homes and 340 assisted living/residential care facilities.<sup>9</sup>

For family members or other caregivers that are providing care for clients in their own homes, respite-care services or adult-daycare services are types of in-home services that can provide relief for caregivers in Oregon.

### **Adult Foster Homes**

These are individual, private residences licensed to provide care for five or fewer residents. They offer room, board, personal care, and 24-hour supervision. Planned activities are available, and some homes provide transportation services, private rooms or nursing services. A wide variety of residents are served in adult foster homes, from those needing only room, board and minimal personal assistance to those residents needing total custodial care and skilled nursing tasks. The care provided depends on the client's needs and the skills, training and abilities of the provider. Adult foster homes are inspected, licensed and monitored by the state or an Area Agency on Aging. About 50 percent of the adult-foster-home clients in MWVSSA's service area are private-pay clients.<sup>10</sup>

### **Assisted Living Facilities**

These are homes with six or more private apartments. They are fully wheelchair accessible and offer full dining room services, housekeeping, and call systems for emergency help when needed. A registered nurse is always available for consultation. The very first assisted living facility in the country opened in Oregon. These homes follow guidelines that promote the residents rights to privacy, personal choice and independence. The state inspects, licenses and monitors these facilities. About 55 percent of the assisted-living clients in MWVSSA's service area are private pay clients.<sup>11</sup>

### **Residential Care Facilities**

Residential care facilities are homes licensed to serve six or more residents. They offer room and board with 24-hour supervision, assistance with physical care needs, medication monitoring,

planned activities and often transportation services. Some offer private rooms and registered nurse consultation services. Residents can need no more than moderate assistance with personal care and behavior. The state inspects, licenses and monitors these facilities. About 68 percent of the residential-care-facility clients in MWVSSA's service area are private pay.<sup>12</sup>

### **Nursing Facilities**

Nursing facilities provide nursing and custodial care on a 24-hour basis for persons who require assistance with their activities of daily living and 24-hour nursing care. These facilities provide skilled care, rehabilitation and end-of-life care. Nursing facilities are most appropriate for people who need a more protective setting, and many residents have medical and behavioral needs that cannot be met in other care settings. About 63 percent of the nursing-home clients in MWVSSA's service area are private-pay clients.<sup>13</sup>

Oregon requires that all residents be screened before they enter a nursing facility. This screening helps determine the level of a client's impairments. Since 1985, the Oregon system has used a priority system for service based on a client's impairment level. There are 17 priority levels. Level one is the most impaired client, a client who is dependent for help with mobility, eating, toileting and cognition.

This screening assures that the resident's care needs are appropriate for a nursing facility, and it helps family members explore other possible care settings. Nursing homes are inspected, licensed and monitored by the state in compliance with both state and federal regulations.

For Oregon, as of December 2000, 46.03 percent of the 13,649 nursing-home residents, 31.25 percent of the 9,803 assisted-living residents, 39.78 percent of the 8,565 adult-foster-home residents and 20.99 percent of the 7,113 residential-care-facility residents were Medicaid clients.<sup>14</sup>

### **Oregon's System Controls Cost**

**As a result of Oregon's long-term-care options, an estimated three-fourths of the state's Medicaid clients are served in home and community-based care settings. Unlike most other states, about 50 percent of all Oregon's long-term-care clients live in their own homes.**<sup>15</sup>

Oregon taxpayers benefit from a system that provides choice at a lower cost. Though Oregon is recognized as a leader in quality long-term-care, it contributes less per capita for that care than most other states. In Oregon, the average monthly cost for a client to receive in-home services is \$785. It costs 342% more than that, about \$2,685, for a client to receive services in a nursing facility.<sup>15</sup> Oregon continues to rank lower than most states for its long-term care expenditures per person, age 65 and older. In 1999, Oregon was the 33<sup>rd</sup> lowest in the nation.<sup>16</sup>

The private sector has also benefitted from the development of these community-based-care choices. As the state developed options for Medicaid clients, these choices became available for

older adults and people with disabilities that weren't eligible for Medicaid. Care recipients who could afford to pay for their care also wanted to stay in their own homes and communities, and they like having long-term-care choices that cost less than nursing facility care.

### **Oregon's Long-Term-Care Delivery System**

Oregon's service delivery system has made it easier to develop and access community-based-care options and to discourage unnecessary and expensive institutionalization. To keep the services as close to the consumer as possible, state offices and local partners, including Oregon's Area Agencies on Aging, have provided case management and care planning for Oregon's community-based-care system at the local level. The Oregon system provides a one-stop shopping, or integrated access point, for seniors and people with disabilities.

In 2001, it was estimated that in-home services had 48 percent of the clients but only used 28 percent of the long-term-care budget in Oregon. By contrast, 16 percent of the state's clients needed a placement in a nursing home for their care, but this required 42 percent of the budget. When possible, in-home care or placements in other lower-cost settings, has saved the state money and allowed it to serve more clients.<sup>17</sup>

As an Area Agency on Aging, Mid-Willamette Valley Senior Services Agency works with local resources and state and federal funds to help clients determine which care settings will best meet their medical or physical needs. A case manager looks at the assistance a client needs with activities of daily living, such as bathing, toileting, grooming, mobility, cognition and eating, to determine the appropriateness of a care placement. Staff also help clients determine their eligibility for Medicaid or Oregon Project Independence programs to help pay for care, and they help clients access community resources.

### **Oregon Project Independence**

In addition to in-home Medicaid services, Oregon offers Oregon Project Independence (OPI), a state-funded program which helps nearly 3,700 older adults with services in their own homes at a cost estimated at about \$13.7 million for the 2001-2003 biennium.<sup>18</sup> The purpose of the program is to promote independent living for those who might not otherwise be able to remain safely at home. OPI is a state-funded service for clients who are not receiving Medicaid. Fees for OPI are determined by a client's income. A client can own their own home, vehicle and other assets and still qualify.

To be eligible for OPI, a client must reside in Oregon, be age 60 and older (or, if younger, have a diagnosis related to Alzheimer's Disease) and must be assessed as needing assistance with their activities of daily living for personal-care or home-care services. A study, in August 2000, by the Oregon Association of Area Agencies on Aging and Disabilities' Contract/Fiscal Managers estimated that the average cost per unduplicated client was \$1,602 annually.<sup>19</sup>

### Older Americans Act Programs

The Older Americans Act, which was established in 1965, helps older adults, age 60 and older, with nutrition and community support services. It establishes a national and statewide network of Area Agencies on Aging to plan and advocate for seniors at the local level. A new provision in the Older Americans Act, the National Family Caregiver Support Program, will provide caregiver support for the nearly 22-million Americans who provide unpaid care for frail friends and family members.<sup>20</sup>

Mid-Willamette Valley Senior Services Agency manages an array of Older Americans Act programs for the over 70,000 senior citizens in Marion, Polk and Yamhill counties<sup>21</sup>. One of the primary services that the Older Americans Act provides is information and referral to community services. Older adults or their family members can call the agency to receive information about a wide range of community resources in addition to the services that the agency provides.

Under the Older Americans Act, Mid-Willamette Valley Senior Services Agency provides information about community resources from its offices in Dallas, McMinnville, Salem, Stayton and Woodburn and develops area plans to determine the future needs of the region's older adults.

According to the agency's statistics for the 2000-2001 fiscal year, 3,156 unduplicated clients in the three counties were served under Older Americans Act, Title III registered services such as congregational and home-delivered meals, and an additional 12,892 unduplicated clients received other services under Title III. These latter services included nearly 18,700 inquiries for information and assistance; 1,121 hours of senior legal assistance; 276 volunteer health insurance counseling contacts, and 158 translation assistance sessions. The agency was able to leverage funds through the use of volunteers. In the fiscal year ending in 2001, volunteers contributed over 43,771 hours to the agency at a value of \$289,864.<sup>22</sup>

The Older Americans Act also supports the agency's advocacy for the concerns of senior citizens and provides funds for the Senior Mental Health Program (which helped 422 older adults adjust to life changes in 2000-2001).

Mid-Willamette Valley Senior Service Agency's nutrition program provides nearly 800 home-delivered or congregational meals each day from 12 meal sites in Marion, Polk and Yamhill counties. The nutrition program relies on a central kitchen, experienced staff, a registered dietician and hundreds of volunteers who serve or deliver the estimated 208,000 meals served annually.

Nationally, the Older Americans Act binds together 655 AAAs and 232 Title VI Native American aging grantees across the country, providing a support structure for planning, service coordination, oversight, and advocacy. AAAs have the infrastructure in place to provide access to a host of services to older adults which link seniors and their family caregivers to a myriad of

service providers in the community. As such, the role of AAAs has steadily expanded to include programs that were not necessarily envisioned in the OAA.

The typical beneficiary served by an Area Agency on Aging is a woman over age 75, with limitations in activities of daily living, such as bathing, eating and dressing. AAAs throughout the country find that they are working more and more with vulnerable and "hard-to-reach" populations, as well as persons with chronic disabilities of all ages.

Many AAAs manage a variety of funding sources in addition to the Older Americans Act, including Medicaid waivers for home and community-based care, social service block grants, transportation funds, and state-funded in-home service programs. In fact, it is not uncommon for an AAA to coordinate five to 10 different funding sources to meet the service needs of one senior. Of the 655 AAAs across the country, approximately 67 percent are public agencies such as cities, counties, or regional planning commissions and 33 percent are private, non-profit organizations.

### **Threats and Other Challenges Present New Opportunities**

#### **Oregon's Population is Rapidly Aging**

Oregon is graying faster than other states. Currently, the state is 10th in the nation in the number of people over the age of 65. In 10 years, it's projected that Oregon will rank fourth with almost 200,000 more men and women over the age of 65, and this trend will continue into the following decade. The fastest growing age group in Oregon consists of those over the age of 85, and it's projected that this age group will double in size in 20 years. Nearly 10,000 or 17 percent of this population group in Oregon are low income.<sup>23</sup>

At the same time, the "baby boom" generation, those individuals born between 1946 and 1964, the largest single population cohort in the history of the United States, are advancing towards their senior years. Boomers will begin turning 60 in the year 2006, only four years from now. Between 1998 and 2010, the number of 60 to 64-year-old residents in Mid-Willamette Valley Senior Service Agency's service area is expected to increase by 74.4 percent, with the age 85 and older group increasing by 44.8 percent in that same period of time.<sup>24</sup>

#### **Planning for Increased Demand**

As part of a strategy to free up future resources, the agency moved into a new Salem headquarters building in 1999 and also into a new Yamhill County building in 2000. Both facilities were developed under lease/purchase arrangements.

For both buildings, planning began with a feasibility study. When the studies were completed, it was revealed that the cost of purchasing and operating space would cost less than leasing space. By developing these two new facilities, Mid-Willamette Valley Senior Services Agency is strategically positioning itself for the coming growth in the area's aging population and the



growth in the agency's caseloads. At both facilities, the agency will own the building and land after 15 years.

### **Creating Funding Increases From Existing Funds**

When the buildings' loans are paid, the significant financial resources once dedicated to rent payments can be redirected into expanding and enhancing funding for programs and services for seniors in Marion, Polk and Yamhill counties. In Yamhill County, after the building loan is paid in 2015, the agency will have \$136,680 a year, and when the Salem building's loan is paid for in 2013, the agency will have an additional \$364,548 a year for client services.

### **Partnership in Food Service Delivery**

#### **History**

Another innovative way that MWVSSA has stretched limited resources has been to develop a partnership with two other Oregon AAAs, Oregon Cascades West and Lane Council of Governments, to provide food services under the Older Americans Act to a seven-county area. This partnership began in 1992 when the three agencies recognized that opportunities existed through regional cooperation to accomplish efficiencies and economies in service delivery without the loss of quality. Realizing that future funding expectations in Oregon could lead to reductions in services to clients, the three governing boards decided to take a pro-active role, instead of a reactive role, in the future direction of one of their agency's most visible services, the Senior Nutrition Program.

In the Spring of 1992, the three agencies consolidated their efforts for food production and delivery to seniors in the seven counties served by the agencies. The governing boards of the three agencies set forth the following goals to be achieved through their cooperative arrangement:

- Reduce food service costs to participating agencies, while maintaining service quality.
- Improve efficiency of food production and delivery.
- Coordinate and consolidate food service contract management.
- Through the economies of scale, maximize current resources for Nutrition Services.

#### **Process**

In order to accomplish these goals, staff of the three agencies spent almost a year defining detailed service specifications that would ensure product quality and maximize current resources. A Request For Proposals was released in order to identify the most responsive provider to contract with for the provision of meal preparation and delivery services out of three central kitchens.

As defined in the Memorandum Of Understanding of the three agencies, a joint Food Service Selection Committee was formed consisting of four voting representatives from each agency. These representatives were selected from the advisory councils of each agency and charged with the task of evaluating and scoring the proposals and developing a recommendation for award of

the food service contract. The consolidation of efforts of the three agencies resulted in a contract award that produced immediate financial rewards to all three agencies. As an example, the per-meal reimbursement rate for MWVSSA went from \$2.20 per meal down to \$1.94 per meal, an initial 12-percent reduction in the per-meal cost. Today, MWVSSA pays only \$.53 cents more per meal than it was paying prior to the 1992 consolidation and would pay \$3.42 if the consolidation had not occurred. This consolidation of efforts has produced a per-meal price which is 28 percent lower than it would be without the partnership.

#### **Program Enhancements**

Currently, the joint food services contract provides nearly 650,000 meals each year to approximately 11,000 seniors in 32 communities. During the ten years of this project, the three programs have realized an overall estimated combined cost savings in excess of \$1,800,000. These cost savings have not only allowed the three agencies to feed more seniors, but has provided them with funds to implement many program enhancements. The introduction of a dual entree system at all of the meal sites was one of the most significant. Each day, home-bound seniors and meal-site participants have a "choice" in ordering one of two daily hot entrees, including one "heart-healthy" choice per day. In addition, these savings have allowed the agencies to maintain a quality program that provides "from scratch" cooking tailored to the tastes of northwest seniors. Other program enhancements include theme menus for special events which promote one of the Older Americans Act goals to help older adults socialize.

In 1996, a frozen-meal program was developed to supplement hot-meal service to seniors on weekends. This program also provides meals to eligible seniors in rural communities and to those who live beyond the hot-food, service-delivery area. Seniors are able to make their meal selection from a menu offering 12 complete frozen meals. The ability for clients to make a choice in what they order is one of the significant reasons for the growth in this program. Since the frozen meal program began, demand has steadily increased from 68,000 meals per year to its current level of over 110,000 meals annually, an increase of nearly 62 percent.

In July 2002, a third menu choice will be introduced to attract new participants and to meet the changing eating habits and tastes of current meal-site participants. This third menu option will be a meal that is more like a lunch than a dinner, so it will be a lighter meal than the currently offered hot meal.

The graph at the end of this document visually demonstrates how the food service consortium has lowered unit rates. The creative efforts of these agencies have reduced costs while increasing the number of meals served, improved the efficiency of food production and delivery, enhanced the nutritional quality of meals and eliminated unneeded duplication of facilities and effort.

#### **An Example of Investment of Savings**

In March 1996, MWVSSA had 40 monthly payments remaining on the central kitchen's lease/purchase agreement. The agency had specifically requested a prepayment clause be included in the lease/purchase agreement, so it had the ability to realize cost savings and make

the best use of public funds. Utilizing savings from prudent spending and cost savings from the joint food service project, in June 1996, MWVSSA preceded with the full pre-payment of the lease/purchase agreement. It became the owner of the central kitchen facility which was built in 1989. The pre-payment resulted in a cost savings in public funds in the amount of \$25,723.28 due to a savings in interest payments. In addition, the annual loan payment of \$73,456.32 became unencumbered. These funds became available to meet an increased demand for nutrition services.

#### **Consortium Approach to In-home Services**

In addition to the successful food service consortium, Mid-Willamette Valley Senior Services Agency is working with Lane Council of Governments and Oregon Cascades West Council of Governments to jointly contract for in-home services for clients.

Since entering into a contract three years ago, the following outcomes have been identified:

- Client services have been improved through standardization of personal and home-care programs.
- The growth of program costs has been controlled.
- Quality assurance mechanisms have been strengthened.
- A large enough volume of work to stimulate interest and competition for bids from possible providers has been created.

Thank you for the opportunity to share information with you about Mid-Willamette Valley Senior Services Agency, the National Association of Area Agencies on Aging and Oregon's long-term-care system. We believe we've offered some suggestions that can benefit other agencies around the country. I look forward to answering questions and would be glad to provide you with additional information.

## Footnotes

- <sup>1</sup> Mid-Willamette Valley Senior Services Agency's Annual Report, 2000-2001, p.9.
- <sup>2</sup> Special session closes with no tax increases, Statesman Journal newspaper, March 3, 2002.
- <sup>3</sup> Oregon sees no relief from recession in January, Oregon Employment Department News, February 15, 2002.
- <sup>4</sup> Mid-Willamette Valley Senior Services Agency's Program Activity Cumulative Monthly Report, December 2001.
- <sup>5</sup> Revenue Sources, Department of Human Services, Senior and Disabled Services Division, 2001 Ways and Means Presentation, p. 2-5.
- <sup>6</sup> The "Oregon Model," Department of Human Services Web site, March 3, 2002.  
[Http://www.sdsd.hr.state.or.us](http://www.sdsd.hr.state.or.us).
- <sup>7</sup> Ibid.
- <sup>8</sup> Senior and Disabled Services Division booklet.
- <sup>9</sup> Smart Government, The Value of Oregon's Long-Term Care System, Oregon Association of Area Agencies on Aging and Disabilities, January 2002.
- <sup>10</sup> Mid-Willamette Valley Senior Services Agency's monthly staff reports, Medicare Compare Web site.
- <sup>11</sup> Ibid.
- <sup>12</sup> Ibid.
- <sup>13</sup> Ibid.
- <sup>14</sup> Percent of Long-Term care clients by type of service, Department of Human Services, Senior and Disabled Services Division, 2001 Ways and Means Presentation.
- <sup>15</sup> Ibid.
- <sup>16</sup> Annual Medicaid Long-Term care expenditures per person age 65 and older, Department of Human Services, Senior and Disabled Services Division, 2001 Ways and Means.
- <sup>17</sup> Percent of Long-Term Care Cost by Type of Service, Department of Human Services, Senior and Disabled Services Division, 2001 Ways and Means Presentation.

<sup>18</sup> Speaker's Task Force on Funding for Senior and Disabled Services, 2001.

<sup>19</sup> AAA OPI Survey 2000, O4AD Contract/Fiscal Managers, August 2000.

<sup>20</sup> Congress Needs a Victory for Seniors: Pass the Older Americans Act, by Janice Jackson, Executive Director, National Association of Area Agencies on Aging.

<sup>21</sup> Portland State University Center for Population Research and Census.

<sup>22</sup> Mid-Willamette Valley Senior Services Agency's Annual Report, 2000-2001.

<sup>23</sup> Smart Government, The Value of Oregon's Long-Term-Care System, O4AD, January 2002.

<sup>24</sup> Portland State University Center for Population Research and Census.

Senator CRAIG. Barry, thank you very much. I have watched Oregon from Idaho for a good number of years, and I know that in the areas that you are involved with, there has been a great deal of effort to innovate and create different approaches.

This would be a question for both of you. First, Joan, and then, Barry, you mentioned that you had "saved lots of money." But Joan, in your testimony, you cited a startling statistic that Ohio's home- and community-based Passport Medicaid waiver program keeps people out of nursing homes and in their homes for about \$11,000 per year versus \$52,000 a year that a nursing home would cost—and yet you testify that Ohio this year is cutting the Passport program and not nursing home care.

If the cost-effectiveness of home-based care is as dramatic as you say, I guess I would have to ask why is the legislature doing that? But I would also then ask the question of Barry, can you give us some similar analyses, particularly because you have spoken to similar savings that have occurred in Oregon by shifting away from institutional care and toward home and community-based care?

Ms. LAWRENCE. Thank you, Mr. Chairman.

Actually, the 6 percent cut came from the administration. As you know, States have to have a balanced budget, so it was simply that we had to come up with—I think it was \$1.5 billion that they were looking for. They protected Medicaid from cuts—

Senator CRAIG. So it was a holdback based on budgets?

Ms. LAWRENCE. Yes. There was no real discussion of whether or not to cut nursing homes per se. There is going to be conversation not just about nursing homes but about hospitals. We have already negotiated, as some of the other speakers have alluded to, a change in our prescription drug reimbursement. We are going from the average wholesale price minus 11 to average wholesale price minus 9—or am I saying it the wrong way—in any event, the way it saves more money. The pharmacists are challenging that, but I suspect it will hold up.

So our Medicaid director has listed a variety of things that might keep us in check. She did, however, testify at the legislature a week or so ago that she felt that through the end of this fiscal year, through June 30, she would not have to propose additional cuts. Next year, the Governor is assuming that some of the cuts will continue, including ours. When I said I was hoping I could get him to change his mind, it was for next year; I am going to be saying just what I said here.

Senator CRAIG. I see.

Barry.

Mr. DONENFELD. In our State, I think we have had the opposite experience. We have been on a 20-plus-year journey of essentially having as many of the people who qualify for Medicaid long-term care be in community-based settings as opposed to nursing homes, to the point where now only one in four of our Medicaid long-term care clients are in a nursing home setting, and the other 75 percent are in some type of—

Senator CRAIG. But comparatively speaking, how much does community-based care save over what would be a contemporary nursing home cost?

Mr. DONENFELD. Our community-based rate, which is then a blend of all the different community settings, some higher and some lower, runs at about \$785 a month, and our nursing home runs at around \$2,800 a month—so roughly four-to-one. That has been fairly consistent over the 20 years. The rates, of course, over that period of time have all gone up due to inflation, but that ratio has remained fairly constant.

We have also learned that any time we have attempted to reduce access to community-based options, the nursing home counts do in fact go up, and you wind up spending the same or more dollars because of the entitlement to the nursing home placement than you do, and you are serving people in ways that they do not wish to be served.

So we have deliberately, I think, in a bipartisan way in Oregon prioritized maintaining the community-based side of the long-term care system as a very high priority.

Senator CRAIG. One last question before I turn to my colleague. Mr. Donenfeld, you singled out specific ways that you and your programs have stretched existing dollars to better maximize service to seniors, and I am particularly interested to your approach of pooling resources and purchasing among different area agencies on aging in your region.

In your experience in Oregon and as the national President of the Association of Area Agencies on Aging, do you believe that this kind of pooled approach could or should be used more widely nationwide, and can such pooling and group purchasing be done in the absence of special waiver circumstances such as you have in Oregon?

Mr. DONENFELD. Let me try to answer all of those questions. Yes, I believe it could be done in many parts of the country. This is an Older Americans Act program, so it does not require any special waivers. It is something that each State could do, depending on the view of the State Unit on Aging toward these arrangements. Our State Unit on Aging was extremely receptive and extremely cooperative, and I would imagine that most of the State Units on Aging would be with a project like this that has the ability to both stretch resources and actually improve the daily quality of the program at the same time.

Should it be used? I think that in our area, it was relatively easy to make that decision because the population dynamics of the seven counties are very similar. The profile of the older people who live in the seven counties, even though they are served by three different agencies, is very similar.

So I think that in places where those kinds of similar profiles would exist, it would be very simple to take this approach. In other parts of the country—take the San Francisco Bay area, where there are multi-ethnic and cultural groups, many of which have separate meal programs that serve ethnic food based on the diversity that exists there—it might be much harder to take that kind of approach, because a contractor would not get the economy of scale that he got from being able to cook the same menu for essentially three times as many people as he would if each of us had bid our program separately.

Senator CRAIG. I see. Good point.

Mr. DONENFELD. So I think that is applicable in many parts of the country where there are geographically contiguous areas with similar profiles; in other areas, it may not be so applicable.

Senator CRAIG. Thank you.

Let me turn now to my colleague, Senator Carper.

Senator CARPER. Ms. Lawrence, where do you live?

Ms. LAWRENCE. I live just north of Columbus.

Senator CARPER. In Worthington?

Ms. LAWRENCE. Close.

Senator CARPER. Where?

Ms. LAWRENCE. Southern Delaware County; close to Worthington.

Senator CARPER. No kidding. I am from Delaware.

Ms. LAWRENCE. Whom do you know in Worthington?

Senator CARPER. I went to Ohio State; I know a lot of people there. I went to Whetstone High School, graduated from Whetstone High School.

Senator, if you will just indulge me, I went back to my high school reunion about 2 years ago. I was Governor then, and I drove in with a State trooper. We were trying to find this golf club where they were having the reunion for Whetstone High School. It was getting close to 7 o'clock, and at 7 o'clock, they were supposed to take the class picture, and the last thing I wanted to do was to miss being in the class picture having driven all the way from Delaware to be there for the event.

If you know where the Columbus zoo is, this golf course was close to the Columbus zoo. We found the zoo, but we could not find the golf club. So it was 6:45, and time was bearing down on us, and we decided to stop at a convenience store and get directions.

A friendly looking fellow was coming out of the convenience store, and I said, "Sir, we are trying to find my high school reunion. It is at such-and-such golf course. Could you tell us where it is?" He said, "It is not far away. Go down there, take a left, then a right, and it is about a mile." We said thanks a lot, and he asked, "Where are you from?" I said, "I am from Delaware." He said, "What do you do there?" At the time, I was Governor of Delaware, and I said, "I am the Governor." Keep in mind, for people who do not know, that Delaware is a little town 30 miles north of Columbus. He said, "Well, I work in Delaware almost every day of the week." I could just see this guy going to work on Monday morning, saying, "I did not know we had our own Governor. I thought Taft was Governor. I met this guy at the convenience store, and he said he was the Governor." [Laughter.]

Ms. LAWRENCE. I believe it—and I think, by the way, in Delaware County at last count, we had 30 golf courses, so no wonder you could not find it.

Senator CARPER. I served with Bob Taft, your Governor, and he is a good friend, he and Hope, so when you see him, give him our best from the "other" Delaware, if you would.

Would each of you take a minute and describe for us the prescription drug assistance programs that your States offer to senior citizens?

Ms. LAWRENCE. Well, my description, Mr. Chairman, Senator Carper, is not going to be very long because unless they are on



Medicaid, we do not do much. We do have in our department a Golden Buckeye Card program which offers 10 percent discounts in retail stores that participate, and many of the pharmacies do.

The Governor this session of the legislature has been trying to get, with our help, an extension of that discount so that it could be more like 20 percent, or 25 percent, with help from the pharmacists and with help, we hope, from the manufacturers with rebates through, perhaps, a prescription benefit manager. But that bill has not yet made it through the process, largely because the pharmacists and the retail chains are very upset that some of that discount comes out of their pockets.

We are still hopeful that we can get it. I keep thinking we should be able to turn the argument, because the pharmacists do grant those discounts to everybody who has insurance coverage or who is on Medicaid, but this last full-paying customer, the senior without coverage, is to pay full price so that they can protect their profit margin.

In any event, we do hope we get it. Unfortunately, I do not have any other piece of decent news. There are a lot of people talking about the tobacco money, so they set aside \$500,000 for prescription benefit assistance, but no one has been able to figure out how to use it effectively. They are considering using it now for advertising the existing discount card programs, which most seniors do not know exist.

So that is not a very good answer, I am afraid.

Senator CARPER. But a straight answer. Thank you.

Mr. Donenfeld.

Mr. DONENFELD. Senator Carper, Senator Craig, my answer would be very similar. Unfortunately in Oregon, we do not have, other than as Joan mentioned, for Medicaid beneficiaries a prescription drug assistance program at all. Our legislature in its last session set aside some funds to start one next fiscal year, which have been cut as a result of our recent budget crisis. It was a very small amount of money, and it was going to provide limited assistance to the poorest of the poor, and now that is not going to happen at all.

So I do not know—given our current budget deficit, with the changes that you referred to, Senator, from the economic stimulus package—there was a report in our local paper yesterday that Oregon is going to lose \$148 million from those changes, which brings our budget deficit up to about \$1 billion. I do not think we will get there any time soon.

Senator CARPER. OK. In our State, we have taken a combination of funds from a foundation, moneys that are donated by a foundation for the purpose of providing for some of the medical needs of our poorest elderly citizens, and we have added to that a portion of moneys that we have received through the tobacco settlement, and we provide prescription assistance to senior citizens, people 65 and over, people who are disabled and unable to work, up to about 200 percent of poverty. In our little State, we have about 750,000 people, but we are able to literally serve the needs of thousands and thousands of people now.

We do not use all the tobacco money for this purpose, but I would say maybe a bit less than half of it. That will probably grow over time.

Delaware is not alone in providing that kind of prescription assistance. Our neighbors in Pennsylvania and other States do as well. Senator Craig, Senator Breaux and I and others are mindful of the interest and I think compelling need for a prescription drug program within Medicare. I think that if we were inventing Medicare anew today, we would include in it a prescription assistance program, because there are so many things that we can do with prescription medicines today that we could not do in, say, 1965.

I think of my own mom, who is an Alzheimer's patient and lives in a nursing home now in Kentucky, close to my sister and close to my mother's sister. She takes any number of prescription drugs which help keep her alive that frankly were not around when Medicare was created. They actually help to give her a pretty decent quality of life given the fact that she has fairly advanced Alzheimer's disease.

We are only going to get better at developing new pharmaceuticals to treat, whether it is Alzheimer's or Parkinson's disease or a variety of other maladies which make the later years of our lives, and sometimes not so later years of our lives, pretty unpleasant. It is important that we have the ability to ensure that as those medicines are developed and can help keep people out of nursing homes or keep people out of hospitals, they are made affordable and available to those who need them.

One of the challenges for us—and it always comes down to money; we have talked about that already, but it always comes down to money—one of the challenges for us is to take the roughly \$300 billion that we put in our budget resolution a year ago for Federal prescription drug assistance and to use that to help meet a portion of the need. It does not begin to meet all of the need that exists.

Someone told me last year that if you added up all the expected or anticipated prescription costs for people 65 and over for the next decade, it would add up to several trillion dollars. Well, let us just say that that several trillion is \$3 trillion—it might be a little more, it might be a little less; we will just assume that it is \$3 trillion—and the Federal Government comes in with \$300 billion. There are a lot of people in our country who get prescription benefits from an employer; they are retired, and they receive some help from their employers. What is important for us is that we actually do agree on a prescription assistance program, and if it is \$300 billion or \$350 billion or \$250 billion, what is really critical is for us to design something so that we do not induce other States to pull out and withdraw their coverage, or that we do not induce other employers—in my own State, Dupont, Hercules, Chrysler, General Motors—they need to stay in the game, providing prescription assistance for their retirees, and for foundations, like the Nemours Foundation in my States, which helps as well.

So the key for us—and it is a tricky one—is, as we develop a program for the Federal Government to provide assistance to some of the neediest people, that we do not provide an incentive for others to cut and run. Right now for States, given the kind of revenue sit-

uations that a lot of our States are facing, if there were a Federal program and States had the opportunity to cut their costs in this area and simply shift the burden over to the Federal Government, my guess is that one or two would.

Ms. LAWRENCE. You would hear the great sucking sound.

Senator CARPER. You surely would. That is one of the challenges that we face and one that, as we go forward, we would welcome your help in addressing.

Ms. LAWRENCE. Mr. Chairman, Senator, you are absolutely right, and the more you leave us hanging out here without prescription drug coverage, the more of us will attempt to come up with something. The maintenance of effort is going to be real challenge. There are some good programs. I wish we could do what Delaware did, but we are a bigger State, and it makes a difference in the ability to even dream about it.

I read recently about an individual city in Kentucky that has put together the kind of package Delaware did—a foundation and then manufacturers' rebates—and they are covering everyone up to 200 percent of poverty. No one has to worry about a prescription. That is good, but of course, it is just that city.

Senator CARPER. It is really good unless you are at 201 percent of poverty, and you have a huge prescription drug need. You cannot wipe every tear from every eye, but we are doing our best to help where we can.

Ms. LAWRENCE. Mr. Chairman, Senator Carper, you are right. The hard part is for you to design something that does not take away all that is already going into it, but I want to go back to something I said about nursing home placement versus home and community-based care and the need for alternatives.

One of the questions we get from the Federal level but also from the State level is if we were to add an ability to pay for assisted living to some extent as a first step—we keep people in home and community-based care, and 50 percent of them eventually do go to a nursing home, but if half of that 50 percent could go in the interim for a year or whatever they could to an assisted living facility, that is a savings right there. How do you keep that from expanding to a much bigger coverage group? Well, one way would be to tie it to the waiver program recipients; start with the people who are already receiving in-home care and can no longer safely stay at home and let them use another system in between.

That would be one way to try to control the costs but do something that is cost-effective.

Senator CARPER. Thank you.

Thank you, Mr. Chairman.

Senator CRAIG. Thank you, Tom.

Joan, Barry, thank you very much for your time and your testimony. It is extremely valuable as we wrestle with this sizable problem in our country that begs for a solution now.

Tom has mentioned his interest, and I share that interest. I hope we can step back from the politics of the issue and look at it anew and design a new Medicare prescription drug program for this country that accomplishes what we want to accomplish as far as seniors and still allows that level of community participation that you are talking about, which is every bit as important for the pay-

ment. What is most important is the community involvement in the caring for our seniors. I do not think we ever want to create a Federal program that just does it all, the character of our country being what it is. I think community involvement will be an extremely valuable part of any solution—the dynamics of those communities, large and small, who reach out, provide for, and participate in the caring for this particular demographic group which is a pretty darn valuable group.

Thank you all very much. The committee will stand adjourned.  
[Whereupon, at 11:21 a.m., the committee was adjourned.]

