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Issue Brief

Medicaid: Focusing on State Innovation

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Introduction: An Overview of the Medicaid Program

The Medicaid program plays a key role in ensuring access to medical and long-term care services for millions of Americans. Medicaid, a jointly funded federal–state health care program for low-income individuals, covered more than 47 million people in 2002—one of every seven Americans.[1,2,3] With financial assistance from the federal government, each state operates a separate program according to broad federal guidelines and a state's own Medicaid Plan. While the federal government has established a framework for Medicaid's mandatory eligibility categories and covered services, states have authority to cover optional groups and services and to determine payment rates for providers. During 2002, Medicaid covered 24 million children, 11 million adults, and more than 13 million elderly and disabled people. Medicaid eligibility generally excludes nondisabled, single adults between the ages of 21 and 64, and childless couples.

As the availability and affordability of private health insurance coverage have decreased in recent years, states have sought to expand their Medicaid programs to provide for those who lose coverage from private sources and to improve coverage for vulnerable low-income populations. These efforts, however, have led to some further declines in private insurance, the magnitude of which is controvertible.[4] In recent years, Medicaid enrollment has increased, after declining between 1995 and 1998.[5] With the downturn in the economy and rising health care costs, many states now face record deficits and shortfalls in their Medicaid budgets. The ability of states to continue to expand their Medicaid programs, or simply to maintain existing eligibility and benefits levels, is questionable. In fact, many states are implementing program changes to slow Medicaid spending growth, including reducing eligibility,

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services, and provider reimbursement rates. The primary challenge facing state policymakers is to maintain the comprehensive set of Medicaid benefits for those who most need it without jeopardizing access to services or quality of care, while at the same time making responsible fiscal choices that ensure the long-run viability of the Medicaid program.

The Current Fiscal Status of Medicaid

In FY 2003, total Medicaid spending will reach $271 billion ($155 billion in federal dollars and $116 in state dollars).[6] In August 2002, the Congressional Budget Office (CBO) estimated that federal Medicaid costs would grow 14 percent during FY 2002 and an average of 9 percent per year between 2003 and 2012.[7] The program accounts for nearly 17 percent of the nation's health care expenditures—more than is spent on Medicare—and is the single largest source of federal financing to states (43 percent).[8] Medicaid is currently the second-largest line item, after education, in most state budgets. States are faced with growth in Medicaid spending due to higher health care costs overall and increasing pressure to provide more services to more people amid a weak economy. While increasing health care costs affect both public and private payers, an economic downturn can accelerate Medicaid spending growth if the unemployment rate rises and income relative to poverty falls, causing eligibility and enrollment to climb. Estimates indicate that a 1-percent increase in the unemployment rate could add 1.5 million people to Medicaid rolls.[9]

During recent years, a majority of states have experienced severe budget shortfalls, both overall and specific to their Medicaid programs. In 2001, Medicaid budget shortfalls averaged 6.2 percent across states, ranging from less than 1 percent of total Medicaid program costs to more than 28 percent of the program costs.[10] Medicaid budget shortfalls in FY 2001 and 2002 totaled $7.1 billion.[11] At the end of 2001, 39 states projected a combined budget deficit of $38 billion for FY 2002. Forty-three states and the District of Columbia reported that overall state revenues were below forecasted levels. Twenty-one states and the District of Columbia reported Medicaid spending above budgeted levels.[12,13] States made $15 billion in cuts in an attempt to close the overall spending gap.[14] Some states also used "rainy-day" funds, tobacco settlement funds, and other one-time-only measures to help balance their budgets, which may have helped forestall cuts in Medicaid spending.[15] However, to the extent these funding sources have been depleted, states will be unable to rely on them to address future budget shortfalls.

The fiscal outlook has not improved. For FY 2003, 41 states projected a Medicaid budget shortfall.[16] In a recent survey of health policy priorities, states say they plan to address these shortfalls by attempting to increase their Medicaid payments from the federal government (40 states), reviewing Medicaid provider reimbursement rates (37 states), exploring the use of Medicaid waivers (37 states), and considering cuts to their Medicaid benefit packages (28 states).[17]

Innovative Strategies to Enhance Medicaid Coverage: The Role of Waivers

Section 1115 of the Social Security Act permits the secretary of the Department of Health and Human Services (HHS) to waive certain portions of the federal Medicaid law so that states can implement five-year demonstration projects. While the federal government has established mandatory guidelines that states must follow in designing their Medicaid programs, states can make substantial changes by using waivers. One important requirement of section 1115 waivers is that states must demonstrate that the authorized activities are budget-neutral to the federal government; that is, states must derive savings somewhere in their existing Medicaid program budget to pay for expansions in coverage or benefits or other waiver activities.[18] Using a waiver, states can create different packages of benefits for different beneficiaries, extend coverage to certain vulnerable populations, offer specific benefits to individuals who are ineligible for the full set of Medicaid benefits, limit mandatory benefits for optional populations, charge cost-sharing for some optional beneficiaries, cap enrollment, or create a time-limited program. States can also change their Medicaid care delivery systems, which in most states has meant moving selected groups of beneficiaries into managed care arrangements.

State-based innovations in insurance coverage often involve public program expansions beyond the federally mandated minimums. Using a Medicaid waiver, states can receive federal dollars for such coverage expansions, rather than using only state funds. This enables states to cover more people than they otherwise could with the same investment of state dollars. Thus, despite recent budgetary constraints, many states have used waivers to increase insurance coverage through their Medicaid programs. Since January 2001, HHS has approved waivers and Medicaid State Plan amendments that have expanded eligibility to more than two million people and enhanced benefits for more than six million people.[19] As of May 2002, 8.2 million individuals received coverage under section 1115 waivers,

accounting for nearly one-fifth of all Medicaid spending.[20]

The Health Insurance Flexibility and Accountability Initiative

In August 2002, the Bush administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative within section 1115. HIFA allows states to expand coverage in their Medicaid and state Children's Health Insurance Program (CHIP) to previously uninsured individuals.[21] In order to adhere to the budget neutrality requirement, HIFA allows states flexibility to expand coverage while reducing benefits, increasing cost-sharing, and limiting enrollment in ways not otherwise permitted. Individuals in the expansion groups include those whom states cannot cover in either Medicaid or CHIP without a waiver, including single adults and childless nondisabled couples under age 65.[22] The HIFA initiative has five major features:

1) It specifically targets individuals with incomes below 200 percent of the federal poverty level, or FPL ($36,200 for a family of four in 2002).
2) It requires states to integrate Medicaid/CHIP funding with private health insurance funding (e.g., premium assistance for employer-sponsored insurance coverage or tax credits for the purchase of individual insurance policies).
3) It maintains existing Medicaid mandatory coverage requirements.
4) It allows states to limit benefits and increase cost-sharing in order to fund coverage expansions within existing program resources.
5) It simplifies the waiver application process by providing application templates and guidance, and expedites the review of state proposals that meet the general guidelines of the HIFA initiative.[23,24]

In a recent survey, 17 states reported plans to submit HIFA applications.[25] As of December 2002, HHS had approved HIFA projects for seven states (Arizona, California, Colorado, Illinois, Maine, New Mexico, and Oregon) and applications were pending from three others (Delaware, New Jersey, and Washington).

The Pharmacy Plus Waiver Initiative

The Bush administration announced the Pharmacy Plus waiver demonstration program in January 2002. This waiver allows states to provide access to Medicaid-funded prescription drug coverage to certain low-income elderly and disabled people who are not currently eligible for Medicaid coverage. According to the Centers for Medicare and Medicaid Services (CMS), the purpose of the Pharmacy Plus demonstration is to provide a subsidized prescription drug benefit that helps individuals maintain good health status and avoid "spending down" to Medicaid eligibility.[26,27] Under the Pharmacy Plus initiative, states can provide various forms of assistance with prescription drug expenses to low-income seniors up to 200 percent of the FPL ($17,720 for an individual in 2002). The benefits package provided under a state's demonstration does not have to be the same as that provided in the Medicaid State Plan. As with other types of section 1115 waivers, the expansion must be budget-neutral to the federal government. States that have existing senior pharmaceutical assistance programs and are willing to revise these programs to adhere to the Pharmacy Plus requirements can qualify for federal matching funds.[28] According to a recent survey, 18 states report that they are seeking or considering waivers for the Pharmacy Plus initiative.[29] As of December 2002, HHS had approved Pharmacy Plus waiver programs in Florida, Illinois, Maryland, South Carolina, and Wisconsin. Applications from Arkansas, Connecticut, Indiana, Maine, Massachusetts, New Jersey, and Rhode Island were pending approval.

Efforts to Control Medicaid Spending Growth

A key challenge for states in the current fiscal climate is to meet increasing demands with decreasing revenues. Finding ways to control Medicaid spending and to use existing resources more efficiently is a priority. According to a recent survey, 41 states plan to take steps to reduce Medicaid spending growth in FY 2003.[30] Because of the federal match, states lose between $1 and $3.31 in federal revenue for every dollar cut from Medicaid, making it costly for states to make direct cuts in spending.[31] Nevertheless, states are implementing cost-containment strategies by limiting eligibility, reducing or eliminating services, increasing beneficiary cost-sharing, and reducing provider fees. Some of these changes can be made without a waiver. For instance, states can eliminate benefits and eligibility groups deemed optional by the federal government.[32] More substantial changes require waiver approval from HHS, such as integrating existing state-funded coverage programs with a state's Medicaid or CHIP program to increase federal financing.

Changes in Eligibility

As of October 1, 2002, 35 states had enacted legislation affecting eligibility for Medicaid and other medical assistance programs.[33] Most of these states expanded eligibility for coverage, with the largest number of expansions relating to eligibility for prescription drug coverage. Only four states enacted eligibility restrictions. Six states expanded coverage for pregnant women, three states expanded Medicaid coverage of HIV treatment and services, and three states expanded coverage for the disabled. Yet in light of tighter budgetary projections for FY 2003, 18 states report that they plan to reduce or restrict the number of people eligible to enroll in Medicaid by restricting opportunities for "spending down" to eligibility, restoring asset and income reporting requirements, and eliminating coverage for certain individuals.[34]

Changes in Services Covered

States that want to preserve eligibility levels are using cost controls that restrict the use of covered services, such as implementing new or higher cost-sharing amounts and limiting the number and generosity of covered services. As of October 1, 2002, 34 states enacted legislation affecting Medicaid benefits, with prescription drugs a primary target.[35] In FY 2002, three states restricted or eliminated adult dental benefits and services for eyeglasses. Twelve states enacted legislation to curtail the costs of prescription drug benefits, including establishing prior authorization rules, limiting the number of prescriptions a beneficiary can fill each month, changing brand-name drug reimbursement rules, and establishing a preferred drug list. For FY 2003, 40 states say they are planning to implement prescription drug cost controls and 15 states plan to increase beneficiary copayments for services other than prescription drugs.[36, 37]

Changes in Provider Reimbursement Rates

While all but two states (Alaska and Wyoming) have enrolled Medicaid beneficiaries in some type of managed care plan, Medicaid services are often still provided on a fee-for-service basis.[38] Therefore, states are responsible for setting both capitated and fee-for-service payment rates for physicians, hospitals, and other providers. Medicaid provider rates are often much lower than rates from private payers, and thus many providers refuse to accept Medicaid beneficiaries as patients. As of October 1, 2002, 32 states enacted legislation dealing with provider reimbursement rates.[39] Most of these laws simply clarified reimbursement rates or procedures. Nine states increased rates to some providers, including physicians, dental providers, rural health clinics, and residential care facilities. Nine states decreased reimbursement to managed care plans, skilled nursing facilities, and other providers. For FY 2003, 29 states plan to cut or freeze provider payments, including hospitals (18 states), doctors (17 states), nursing homes (16 states), and managed care organizations (12 states).[40]

Key Factors Affecting Medicaid Spending Growth

Prescription Drug Use and Spending

Prescription drugs are an optional benefit in Medicaid, but every state has opted to cover them. In 1998, 19.3 million Medicaid beneficiaries received prescription drugs, making them the most commonly used Medicaid service.[41] In 2000, Medicaid spent $16.6 billion on prescription drugs, a relatively small share of overall Medicaid expenditures (approximately 10 percent of FY 2000 spending).[42, 43] Pharmaceutical expenditures are the fastest-growing component of Medicaid spending, however, increasing by an average of 18 percent annually from 1997 to 2000.[44] The Centers for Medicare and Medicaid Services project that Medicaid's prescription drug expenditures will grow 70 percent faster than overall Medicaid growth between 2001 and 2006.[45] Twenty-five states cited spending on prescription drugs as the single most important factor affecting Medicaid costs.[46] Nine other states ranked prescription-drug spending as the second or third most important factor.

Most states have placed controls on the Medicaid drug benefit that apply to both beneficiaries and providers. Such activities include establishing beneficiary copayments, reducing pharmacy dispensing fees, and limiting the number of prescriptions a beneficiary can receive on a monthly basis. Thirty-two states and the District of Columbia impose some beneficiary cost-sharing requirement for drugs, ranging from $0.50 to $5 per prescription.[47] Other strategies to control drug costs that have been adopted include either encouraging or requiring generic substitution (24 states), establishing preferred drug lists (16 states), requiring supplemental rebates from drug companies (12 states), and requiring prior authorization for brand-name drugs (6 states).[48] For FY 2003, states plan to control Medicaid drug costs by setting lower payments for drug products, e.g., average wholesale price less a greater discount (26 states), using preferred drug lists (22 states), establishing new

or higher copayments (19 states), and limiting the number of prescriptions allowed per beneficiary per month (6 states).[49]

In June 2002, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a federal lawsuit against HHS. The pharmaceutical industry claims that preferred drug lists violate the Medicaid law because they restrict access to drugs based upon price as opposed to clinical reasons, and they exclude drugs that have a rebate agreement with HHS.[50] In its lawsuit, PhRMA asks the court to issue a preliminary injunction invalidating the preferred drug lists in Michigan. The court has yet to rule on the case. This lawsuit represents a potential barrier to states' efforts to control Medicaid drug spending using these lists.

The Growing Demand for Long-Term Care

According to CBO projections, services for the elderly and disabled will account for three-fourths of projected increases in federal Medicaid spending from 2001 to 2006.[51] In 1998, spending on long-term care for elderly and disabled Medicaid beneficiaries accounted for 42 percent of national Medicaid spending and 14 percent of all state and local health care spending.[52, 53] Medicaid is the largest public source of funding for long-term care costs, representing 38 percent of total long-term care spending, 46 percent of nursing home expenditures, and 38 percent of home care revenues in 1998. The program covers the cost of care for nearly 70 percent of nursing home residents.[54] Of the $68 billion spent by Medicaid on long-term care in FY 2000, 73 percent financed institutional care.[55]

Pressure on states to finance Medicaid long-term care services will increase as the population ages. By 2030, the over-65 population is projected to double and the over-85 population to triple.[56] States largely control who gets what long-term care services under Medicaid by determining eligibility levels, establishing limits on total enrollment, targeting programs to selected areas and population groups, and regulating the supply of nursing home beds. All states have used federal waivers to design home and community-based care programs to provide long-term care services in community settings rather than in institutions, which can save money. Improving the quality of care in nursing homes and ensuring adequacy of nursing home payment rates are other long-term care policy concerns that states will face in the near future.[57]

The Federal Role in Ensuring the Viability of Medicaid

Although Medicaid was designed to be a state-run program, the use of waivers increases existing cross-state variation in program design and raises concerns about disparities in access. Moreover, the expedited approval of waivers by HHS under the HIFA initiative may be cause for concern, given that some states make significant changes to their Medicaid programs through this process. States' use of waivers to expand coverage and make other changes to their Medicaid program also has mixed repercussions for beneficiaries. The design flexibility of the HIFA initiative could encourage states to use section 1115 waivers to cover uninsured people with at least a basic level of services, rather than leave these people without coverage. Yet in the current fiscal environment, many states might not be able to maintain existing coverage and benefits levels in their Medicaid programs, nor implement coverage expansions to deal with the increase in the number of uninsured. Past experience has shown that progress in reducing the number of uninsured can require significant federal action and federal funding—CHIP is one example. Federal legislative intervention in Medicaid could include allowing states to cover all adults below an established income threshold, increasing the federal matching rate on current Medicaid beneficiaries, and permitting more flexibility in benefit design without waiver authority.[58]

Another key issue for members of Congress concerns changes in Medicaid policy. As waiver use has increased, policy changes have been less frequently determined by Congress and more often designed by states and approved by HHS.[59] The negotiation of Medicaid waiver terms occurs between state agencies and the executive branch, and does not require congressional oversight or approval.[60] In an analysis of the HIFA and Pharmacy Plus initiatives, the General Accounting Office (GAO) concluded that some waivers approved by HHS do not appear to be consistent with public program objectives established by Congress.[61] Thus, defining the appropriate use of Medicaid waivers may warrant attention by members of Congress. Should waiver activities promote experimental and pilot demonstrations among states, expand insurance coverage (without new federal resources), provide states with an avenue to control Medicaid costs, or promote the restructuring of the Medicaid program outside the legislative process?

Conclusion

In recent years, states have adopted innovative approaches to enhance their Medicaid programs to serve more individuals. At the same time, states have implemented ways to control program spending in an era of declining revenues and increasing health care costs. The flexibility granted to states to make changes in their Medicaid programs through the waiver process enables state policymakers to address specific local needs and to enhance the reach and effectiveness of their Medicaid programs. However, the adoption of such changes across states has been uneven, resulting in disparities in eligibility and coverage. Furthermore, while some states use waivers to expand coverage, fiscal pressures have led states to seek waivers to reduce state Medicaid spending in ways not otherwise permitted. Under the HIFA initiative, states that expand coverage are also allowed to reduce benefits, charge higher costs, and reduce access to previously covered services for some beneficiaries in order to maintain budget neutrality. Such cost-containment strategies are not without their disadvantages. For example, cutting Medicaid eligibility or services could increase the burden on public health and uncompensated care systems. Reducing Medicaid provider reimbursement rates may lead them to stop providing services altogether.[62]

Meanwhile, private sector coverage trends do not bode well for states' efforts to control Medicaid program spending. Recent declines in private employer-sponsored insurance coverage could result in increases in Medicaid enrollment. From 2000 to 2001, the percent of people covered by employer-sponsored insurance decreased from 63.6 percent to 62.6 percent, while the percent of people covered by Medicaid increased from 10.6 percent to 11.2 percent—both statistically significant changes.[63] Increased enrollment will test the capacity of states' Medicaid delivery systems, as well as states' ability to ensure the accessibility and stability of Medicaid coverage for current and future beneficiaries. The tensions that have arisen in state Medicaid programs—between expanding coverage and adhering to budget neutrality requirements, and between accommodating rising health care costs and addressing state budget shortfalls—are likely to continue.

State Medicaid Waiver Activity (as of October 2002)

State	HIFA	Pharmacy Plus	Waiver Statute*
Alabama	No waiver	No waiver	Waiver terminated**
Alaska	No waiver	No waiver	No waiver
Arizona	Approved	No waiver	Approved—implemented
Arkansas	No waiver	No waiver	Approved—implemented
California	Approved	No waiver	Approved—implemented**
Colorado	Approved	No waiver	No waiver
Conn.	No waiver	No waiver	No waiver
Delaware	Proposal under review	No waiver	Approved—implemented
D.C.	No waiver	No waiver	Approved—pending implementation
Florida	No waiver	Approved	Proposal withdrawn**
Georgia	No waiver	No waiver	No waiver
Hawaii	No waiver	No waiver	Approved—implemented
Idaho	No waiver	No waiver	No waiver
Illinois	Approved	Approved	Waiver expired
Indiana	No waiver	No waiver	No waiver
Iowa	No waiver	No waiver	No waiver
Kansas	No waiver	No waiver	Proposal withdrawn
Kentucky	No waiver	No waiver	Approved—implemented
Louisiana	No waiver	No waiver	No waiver
Maine	Approved	No waiver	No waiver
Maryland	No waiver	Approved	Approved—implemented
Mass.	No waiver	No waiver	Approved—implemented
Michigan	Inactive	Approved	No waiver
Minnesota	Inactive	No waiver	Approved—implemented
Miss.	No waiver	No waiver	No waiver
Missouri	No waiver	No waiver	Approved—implemented***
Montana	No waiver	No waiver	No waiver
Nebraska	No waiver	No waiver	No waiver
Nevada	No waiver	No waiver	No waiver
N.H.	No waiver	No waiver	No waiver
N.J.	No waiver	No waiver	Approved—pending implementation
N.M.	Approved	No waiver	No waiver
N.Y.	No waiver	No waiver	Approved—implemented
N.C.	No waiver	No waiver	No waiver
N.D.	No waiver	No waiver	No waiver
Ohio	No waiver	No waiver	Waiver expired
Oklahoma	No waiver	No waiver	Approved—implemented

State	HIFA	Pharmacy Plus	Waiver Statute*
Oregon	Approved	No waiver	Approved—implemented
Pa.	No waiver	No waiver	No waiver
R.I.	No waiver	No waiver	Approved—implemented
S.C.	No waiver	Approved	No waiver
S.D.	No waiver	No waiver	No waiver
Tenn.	No waiver	No waiver	Approved—implemented
Texas	No waiver	No waiver	Proposal withdrawn**
Utah	No waiver	No waiver	Approved—pending implementation**
Vermont	No waiver	No waiver	Approved—implemented
Virginia	No waiver	No waiver	No waiver
Wash.	Proposal under review	No waiver	Approved
W.V.	No waiver	No waiver	No waiver
Wisconsin	No waiver	Approved	Approved —implemented***
Wyoming	No waiver	No waiver	No waiver

* According to CMS, general Section 1115 waiver demonstration projects allow states to "test substantially new ideas of policy merit." These projects include covering services and populations not otherwise permitted by Medicaid law, as well as implementing system changes such as managed care enrollment. These waivers are characterized as "comprehensive state health reform" because they are implemented on a widespread basis, usually statewide.

** Less than comprehensive.

*** Combination Title XIX/Title XXI.

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