kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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STATE FISCAL CONDITIONS AND MEDICAID

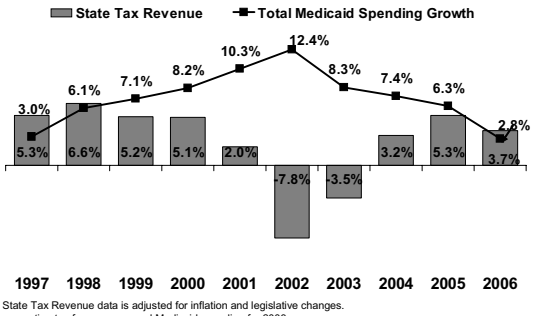
After several years of fiscal stress, state revenues continued to recover and Medicaid spending growth slowed to near record lows in state fiscal year 2006. The Medicaid program provides health coverage and long-term care assistance to over 41 million people in low-income families and 14 million elderly people and persons with disabilities. While policies to control costs remained a priority in FY 2006, states were able to make more program investments than in previous years. In addition to changes in state fiscal conditions, two pieces of federal legislation, the Medicare Modernization Act (MMA) and the Deficit Reduction Act (DRA) affected state Medicaid policies and programs.

STATE REVENUES INCREASING & TOTAL MEDICAID SPENDING GROWTH SLOWING

Beginning in 2001, a severe economic downturn caused state revenues to plummet at the same time Medicaid spending growth peaked as more people became eligible for Medicaid due to declines in employer sponsored health coverage and increasing poverty rates. As the national economy began to recover, state revenue growth rebounded and in FY 2006 exceeded total Medicaid spending growth for the first time since 1998. According to estimates reported by state Medicaid officials, total Medicaid spending growth slowed for the fourth consecutive year to an estimated 2.8% in 2006 (Figure 1).

Figure 1

State Tax Revenue and Total Medicaid Spending Growth, 1997-2006



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimates for revenues and Medicaid spending for 2006.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2006 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

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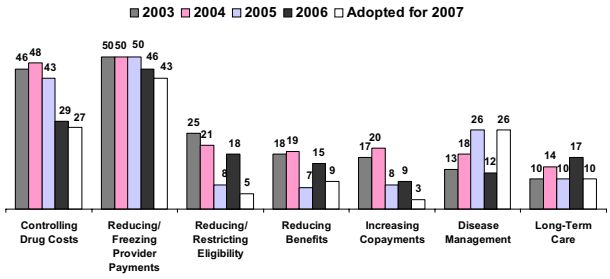
The primary factor affecting the slowdown in spending was the decline in enrollment growth – dropping from a high of 9.9% in 2002 to 1.6% in 2006. States attributed the slower enrollment growth to the improving economy and to strategies put in place to restrict eligibility over the last several years.

The shift of prescription drug spending for the dual eligibles from Medicaid to Medicare on January 1, 2006 as part of the Medicare Modernization Act of 2003 also lowered Medicaid spending growth in FY 2006. States are obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government that states count as state Medicaid spending even though these payments are not matched with federal funds. Without counting these clawback payments, overall spending growth for Medicaid would have been even lower at 1.7%.

Another factor contributing to the slowed spending growth in Medicaid is the cumulative effect of previously enacted cost containment policies. Over the last few years, every state has implemented policies to freeze or reduce provider payments and to control prescription drug spending. Some states also implemented policies to restrict benefits or eligibility to slow Medicaid spending. (Figure 2).

Figure 2

States Undertaking New Medicaid Cost Containment Strategies FY 2003 – FY 2007



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, October 2005, October 2006

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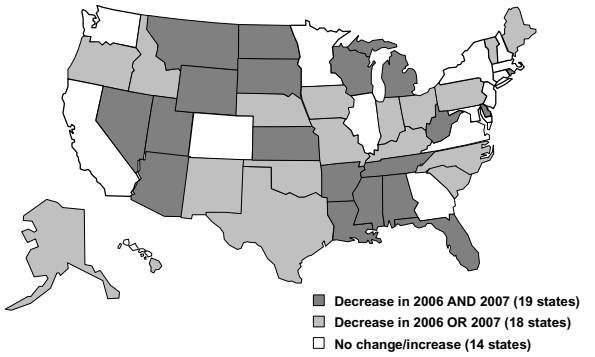
Despite a slowing in total Medicaid growth, state spending on Medicaid grew faster than total Medicaid spending due to the "clawback" payments that are not matched by federal funds, formula driven declines in the federal matching percentage (FMAP), and continued federal scrutiny over state financing for Medicaid. In FY 2006, Medicaid state general fund spending grew by 6.8% compared to total growth of 2.8%; these rates however were well below the projected 11.7% growth included in the original FY 2006 budgets. Excluding the clawback payments, state funds for Medicaid program spending lessened to 4.2%.

The federal government match rate for each state is based on a formula using average state per capita income. The federal matching rate varies by state from 50 to 77 percent and in FY 2006 or FY 2007, three-fourths of states experienced formula driven declines in their FMAP placing pressure on states to allocate additional state general funds to maintain current programs (Figure 3).

Figure 3

Nearly 3 out of 4 States Experienced a Reduced FMAP in 1 or Both Years for FY 2006 and FY 2007



SOURCE: Federal Register, November 24, 2004 (Vol. 69, No. 226), http://aspe.os.dhhs.gov/health/fmap06.htm

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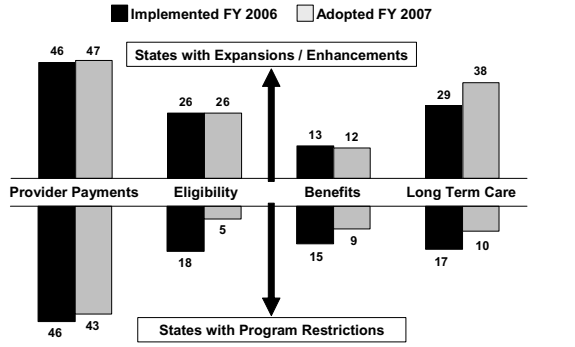
Despite increasing revenue growth, states are still reporting pressure to control Medicaid costs in the face of rising health care costs, erosion of employer sponsored health coverage, enrollment growth and pressure to increase provider rates. States budgeted for total spending growth of 5% and state spending growth for Medicaid of 6% for FY 2007.

A MIX OF COST CONTAINMENT AND EXPANSION EFFORTS

In FY 2006 and 2007 states continued to focus on policies to control costs but improved fiscal conditions allowed for more program investments than in previous years. All states in FY 2006, and 49 states in FY 2007 plan to implement at least one new cost containment strategy. Fifty states in FY 2006 and 49 states in FY 2007 plan to implement program investments, restorations or expansions (Figure 4).

Figure 4

State Policy Actions Implemented in FY 2006 and Adopted for FY 2007



NOTE: Past survey results indicate not all adopted actions are implemented.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2006.

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In 2006 and 2007:

- Nearly equal numbers of states enacted provider payment increases as provider payment restrictions.
- While 18 states cut eligibility in FY 2006 (a few states enacted significant cuts including Tennessee and Missouri), only 5 states are planning cuts in FY 2007. Over half of the states implemented or adopted plans to restore or expand eligibility in FY 2006 and FY 2007.
- Nearly 3 out of 4 states plan to implement long-term care expansions in 2007. The most common expansions include new or expanded home and community-based services waivers (HCBS).

Additionally, over half the states plan to implement disease management programs and quality initiatives for FY 2007 and 21 states have plans for improving program integrity – initiatives that could result in long term savings.

DRA CHANGES

In February 2006, the President signed the DRA placing new requirements (such as new documentation requirements for citizens applying for Medicaid and changes to the asset transfer rules) and new options for state Medicaid programs related to benefits, cost sharing, and long term care. Many states (48) expected the new documentation requirements to increase administrative costs and more than half of the states expect the requirements to negatively affect enrollment. Only three states (West Virginia, Kentucky and Idaho) had approved plans to change benefits using new DRA options but other states are considering these options. Many states plan on using new long term care options to expand the Long Term Care Partnership Programs (22 states) and implement Self-Directed Personal Assistance Services (16 states). States also expressed interest in applying for DRA Grant and Demonstration Programs such as Medicaid Transformation Grants (26 states) and Money Follows the Person grants (18 states).

FUTURE OUTLOOK

Despite notable slowing of Medicaid spending and enrollment growth, pressure to control Medicaid spending remains strong. Requirements to balance state budgets each year, rising health care costs, increasing numbers of uninsured and growing numbers of elderly and persons with disabilities all continue to impose demands on Medicaid. Even with these challenges, a rebounding economy has made it possible for many states to move beyond measures to produce immediate cost savings and focus more on improving the quality and integrity of Medicaid programs across the country. Some states continue to evaluate new options made available in the DRA and other states are focused on expanding health coverage with major reform efforts in states like Massachusetts and Illinois building on a strong Medicaid foundation of coverage and financing. Looking ahead, the outcome of the state and federal elections in November will undoubtedly influence the future direction of Medicaid policy.

For additional information see the report entitled: *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey. State Fiscal Years 2006 and 2007, October 2006* at http://www.kff.org/medicaid/7569.cfm.

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