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STATE MEDICAID CUTBACKS AND THE FEDERAL ROLE IN PROVIDING FISCAL RELIEF TO STATES

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States have just completed one of the most difficult budget seasons in recent years. In the fiscal year that ended on June 30 in most states, legislators had to close budget deficits of $40 to $50 billion. These deficits were caused by a combination of lower-than-expected revenues and higher-than-expected expenditures, including increased Medicaid costs, partly as a result of the rise in unemployment. While there are some signs of an economic recovery at the national level, recent data about state tax collections indicate that state revenues are still falling and it may take an additional 12 to 18 months for state budgets to begin to recover.

Since all but one state operates under a mandate to balance its budget, states have been forced to make tough decisions about taxes and spending. States that have acted to close budget gaps have employed a variety of measures to do so, using a combination of revenue increases, spending reductions, use of reserves C both "rainy day funds" and funds that have been set aside for other purposes C and one-time budget-balancing measures. As Kentucky Governor Paul Patton has noted, "Many governors have exhausted both traditional cost-cutting measures and more extreme measures such as layoffs, across the board program cuts and utilization of rainy day and tobacco settlement funds. As recent economic indicators have demonstrated, our hopes for a rapid economic recovery have not materialized. Without immediate fiscal relief, the cuts necessary to close these budget gaps will have profound effects on our nation's children and the programs which serve our most needy populations."[1]

The outlook for state finances in the next couple of years is equally dispiriting. State revenues are unlikely to rebound quickly, and many of the reserve funds and one-time measures used to balance this year's budgets will no longer be available to fill budgetary shortfalls. When state legislatures meet later in 2002 and 2003, they likely will be faced with fiscal problems as unfavorable (or in some cases worse) as those they encountered earlier this year. The difficult choices of significant additional program cuts and/or tax increases may be unavoidable.

The federal government can play a significant role in providing fiscal relief to states, alleviating the pressure to enact deeper, more damaging cuts, especially in programs that serve low- and moderate-income families, children and seniors. Legislation by Senators Jay

[1] National Governors Association, "NGA Expresses Support for Bipartisan Fiscal Relief Legislation," June 18, 2002.

Rockefeller and Gordon Smith (S.2221) and Senators Susan Collins and Ben Nelson (S.2570) is designed to provide such relief, or in whole, through temporary increases in the federal share of Medicaid costs.

Since Medicaid spending comprises a large share of state budgets, second only to education, the growth of Medicaid expenditures has been particularly serious for states. Medicaid expenditure increases were fueled both by sharp increases in health care costs that have plagued both the private and public sectors and by increases in enrollment caused by recession-related unemployment. According to the National Association of State Budget Officers, 47 states either took steps or proposed steps to reduce Medicaid expenditures in state fiscal years 2002 or 2003.[2] Some of the most common budget-cutting policies included: implementing cost containment programs for pharmaceuticals, freezing or lowering payment rates to hospitals, physicians, HMOs and nursing homes, reducing or eliminating "optional" Medicaid benefits like dental or vision services, increasing beneficiaries' copayments, and, in some cases, scaling back eligibility for Medicaid. Many of these policies C like cutting eligibility C have obvious adverse consequences because low-income beneficiaries lose insurance coverage. Other changes, like cutting payment rates to nursing homes, physicians or hospitals, also can harm beneficiaries because some health care providers may be less willing to serve Medicaid patients or, if they continue to serve them, may provide lower quality health care.

Impact of State Budgets on the Medicaid Program

This brief report describes budget cutbacks in Medicaid and, in a few cases, the State Children's Health Insurance Program (SCHIP) that have been *adopted* for the new fiscal year in a broad array of states with a mixture of Democratic and Republican governors and legislatures. As of July 9, the legislatures in all but five states had completed budget actions for the new fiscal year.[3]

In most cases, the new policies were established by legislative action, but sometimes they were adopted through administrative actions taken by state agencies because the state's appropriations level for the Medicaid program was too low to support the current level of services or because Medicaid expenditures grew faster than expected. The National Association of State Budget Officers has reported that preliminary estimates of Medicaid expenditures for

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[2] National Association of State Budget Officers and National Association of Governors, "Medicaid and Other State Healthcare Issues: The Current Situation," May 2002. When this report was written, final state actions for 2003 had not been completed. The details of governors' budget proposals were all that were reported.

[3] The five states that have not yet completed their state fiscal year 2003 budgets are California, Kentucky, Massachusetts, Michigan and North Carolina. In addition, five states have biennial budgets and did not convene a regular legislative session this year.

2002 exceeded the states' original appropriations by $2.8 billion.[4] Shortfalls like these occurred in more than 30 states. Many states are likely to face similar problems in the coming year because of continuing economic and fiscal difficulties. Health care costs in both the private and public sectors are continuing to rise faster than were earlier anticipated, as reflected, for example, by double-digit increases in private insurance premiums. In addition, the economy has not recovered as strongly as many forecasters had earlier predicted and unemployment remains high, with the result that Medicaid enrollment levels may be higher in the new state fiscal year than states projected when put together their budgets. Furthermore, many of the budgets states adopted in recent months are based on assumptions that state revenue collections will be stronger in the new fiscal year than now seems likely. The latest data show that revenues are still falling in many states. As a result, revenues in many states are likely to come in below the budgeted level, while costs for Medicaid could exceed the budgeted amount. The cumulative effect is that, in addition to the budget cutbacks already planned or implemented, many states may feel compelled to adopt further Medicaid cutbacks during the course of the coming year.

The following are examples of states that have adopted cuts in their Medicaid programs in recent months:

- ***Missouri***. Missouri enacted a series of changes to reduce its Medicaid expenditures by more than $360 million. Insurance coverage was eliminated for about 36,000 low-income parents, primarily by lowering the eligibility limit from 100 percent of the poverty line ($15,000 per year for a family of three) to 77 percent of the poverty line ($11,600 for a family of three). In addition, for hundreds of thousands of Medicaid beneficiaries, the services that Medicaid covers are being cut back substantially. For example, coverage for health services for new mothers, including family planning and postpartum services, was reduced, affecting more than 160,000 women. Dental services were eliminated for low-income adults, affecting about 300,000 people. Missouri also imposed stricter limits on which drugs can be prescribed without prior authorization.

- ***Tennessee***. Tennessee is adopting major changes in design of its Medicaid waiver program C called TennCare C that are expected to lead roughly 70,000 to 100,000 beneficiaries to lose coverage and cause hundreds of thousands to be covered for fewer services. The changes, which are too complex to describe in this paper, will essentially reduce and restructure benefits and often increase cost-sharing for those who have incomes above the traditional Medicaid eligibility levels but below 200 percent of the poverty line. Even with these cuts, the state expenditures for TennCare are slated to rise from $1.8 billion last year to $1.9 billion this year.

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[4] National Association of State Budget Officers, *op cit.*

- ***New Jersey***. On June 15, New Jersey began implementing a series of changes in its joint Medicaid-SCHIP program, NJ FamilyCare. The state will no longer accept new applications from low-income parents unless their incomes are at or below the state's income limit for the receipt of welfare benefits. This effectively reduces the income eligibility level from 200 percent of the poverty line to thousands of dollars below the poverty line. Currently, more than 100,000 low-income New Jersey parents receive benefits from NJ FamilyCare; that number served will now fall sharply through attrition. In addition, the state is reducing and restructuring benefits for non-elderly adult beneficiaries, including both parents and childless adults, to limit costs further. Some of those affected by these benefit changes have severe physical or mental health conditions.

- ***Florida***. Florida approved a number of reductions in its Medicaid program. The largest is the elimination of all non-emergency adult dental services for Medicaid beneficiaries, which will cause 28,000 Floridians to lose these services. The state also cut the Medicaid income limit for poor elderly and disabled individuals who are not eligible for SSI from 90 percent of the poverty line to 88 percent of the poverty line, affecting 6,900 individuals. In addition, the state abandoned plans to implement the "Ticket to Work" program, which was slated to expand Medicaid coverage for disabled people returning to work. The abandonment of this initiative will affect an estimated 1,500 disabled adults. Finally, although the legislature funded the state's "medically needy" program, which covers low-income adults with catastrophic medical expenses, through May 1, 2003, it did so with a one-time funding source. If additional funds are not found, the program is slated for elimination next May 1. If that occurs, thousands of low-income individuals with high medical bills will lose coverage.

- ***Georgia***. Georgia made several cuts in Medicaid. The most significant such action cuts in half C from 24 months to 12 months C the amount of time that a low-income working family is eligible to receive transitional Medicaid coverage after leaving welfare. The state estimates that 5,000 adults will lose health coverage as a result. In addition, the state eliminated a plan that would have limited out-of -pocket premium costs for families of 58,000 children with incomes between 100 percent and 150 percent of the poverty line.[5] The state also dropped plans to proceed with a pilot program to allow disabled working people to "buy into" Medicaid. Finally, Georgia limited access to some prescription drugs and slowed a planned phase-in of new slots for its Community Care Services Program, which would help disabled people obtain care in the community.

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[5] Georgia planned to increase Medicaid eligibility for children up to 150 percent of the poverty line. Though these children were already eligible for SCHIP, enrolling them in Medicaid would lower cost sharing and give them access to a fuller benefit package.

$ ***Iowa***. Iowa reduced dental services for adult Medicaid beneficiaries, scaling back its comprehensive dental package to a set of basic preventive services. Services eliminated include treatments such as endodonture and periodonture. The state estimates that as many as 142,000 Iowans could be affected by this reduction in services. Iowa also is facing a deep budget shortfall for next year.

$ ***Montana***. Because of its budget difficulties, Montana has substantially increased the amount that adult, elderly, and disabled Medicaid beneficiaries must pay when they use medical care services. Effective last April, Montana requires that beneficiaries cover five percent of the cost for most medical services, including prescription drugs and doctors' office visits; the charge for hospital admission is $200. Patients will be assessed these fees regardless of income. These high copayment levels could lead many patients to avoid or delay getting medical care because they cannot afford the out-of-pocket costs. In addition, health care provider reimbursements have been reduced by 2.6 percent, except nursing home payments. This could affect provider participation in the Medicaid program. Funding for the state's SCHIP program for 2003 was initially frozen at the same level as for 2002 and was reduced *below* that frozen level for state fiscal year 2003. SCHIP enrollment has been capped since January 2001, and the state has placed eligible children on waiting lists.

$ ***Washington***. Washington state reduced its Supplemental Security Income program, which will cause certain elderly and disabled beneficiaries to lose their Medicaid eligibility as well as state SSI benefits. The state also has imposed new cost-sharing and premium requirements on certain Medicaid beneficiaries, including optional copayments for emergency room services and premiums for the second six months of transitional Medicaid coverage for those leaving welfare for work. The policies that will have the largest impact on Medicaid beneficiaries, however, are those likely to be proposed by the state under a Medicaid waiver. While the waiver would include some expansions of health care coverage to new groups of beneficiaries, it is also expected to cap Medicaid enrollment levels C with the result that some currently eligible people could be placed on waiting lists C and to limit benefits for certain Medicaid clients while increasing the premiums and cost-sharing that some low-income families must pay. Washington state's initial waiver proposal was returned to the state by the U.S. Department of Health and Human Services; HHS requested further detail. The state is expected to submit its waiver in revised form in the near future.

$ ***Wisconsin***. On July 7, the Wisconsin Assembly joined the Senate in passing a budget for the new fiscal year. Under the budget that was sent to the governor, both Medicaid and SCHIP are underfunded; the appropriations levels are about

\$60 million below the amount the state's Legislative Fiscal Bureau estimates to be necessary. If the Legislative Fiscal Bureau's analysis proves to be correct, the state will have to take action in the coming year to reduce Medicaid and SCHIP costs. Furthermore, the state's large budget deficit was closed by consuming the state's tobacco settlement, a one-time budget fix that will not be feasible next year. There is a serious risk of further benefit cuts next year.

The reports listed above are for states that have adopted budgets for the state fiscal year that began on July 1. Additional budget cuts are expected in some of the states that are still wrestling with their budgets.

A Temporary Increase in the Federal Medicaid Matching Rate Could Provide Needed State Fiscal Relief

According to the National Governors Association, keeping up with Medicaid spending has been extremely difficult for states. Program expenditures rose an average of 12 percent per year over the last two years, while state revenues rose a cumulative total of five percent. Medicaid expenditures have been driven higher by increases in health care costs C for example, Medicaid costs for prescription drugs have increased by 18 percent annually over the past three years C and by recession-related increases in the number of people eligible for Medicaid. The rising costs of health care are not affecting the Medicaid program alone but are also increasing private health care costs and the costs of insurance for federal, state and local government workers.

In the past two years, almost all states have implemented Medicaid budget cutbacks, so far, most have been able to avoid the most damaging cuts, such as scaling back eligibility for low-income beneficiaries. In the next year or two, however, the pressure to cut Medicaid eligibility or services will intensify. Many of the budgets approved by states this year relied on one-time budget fixes, like using all of the state's future tobacco settlement funds. Such resources cannot be used to close budget gaps again next year if, as appears increasingly likely, fiscal conditions continue to be grim. Similarly, in the past year, a large share of Medicaid cuts involved developing prescription drug cost containment plans or reducing provider payments. As these options are exhausted, the pressure to scale back eligibility or benefits will rise. Hundreds of thousands of low-income children, families, seniors and people with disabilities could lose coverage or see major reductions in the scope of their insurance coverage or benefits. While states' economies will eventually improve, the prognosis for the next 12 to 18 months continues to be bleak.

Exacerbating these problems, many states will have to reassess their budgets this fall and winter in light of new economic data. Even though most states appear to have balanced their budgets for fiscal year 2003, many are expected to impose harsher cutbacks during the course of

the year. As previously noted, in developing their Medicaid budgets, the great majority of states assumed that state revenues would rebound in the upcoming year and health care expenditures would rise at a moderate level. Unfortunately, disappointing economic trends have continued and health care costs are rising sharply. Many states are likely to be placed in the difficult position of being squeezed by falling revenues and rising health care costs at the same time. The result is substantial risk that further Medicaid cutbacks may be required this fall or early in calendar year 2003.

The Medicaid budget problems states are experiencing are being exacerbated by reductions in federal Medicaid matching payments to some states, which are based on the "Federal Medical Assistance Percentage" or FMAP. The FMAP is designed so that federal matching rates are higher for poorer states than for wealthier ones and are based on historical economic data. Unfortunately, the rates for 2002 are based on economic data *from the late 1990s*, when states' economies were booming. Even though the economy has weakened greatly since then, the federal Medicaid matching rates for 29 states *declined* in 2002, and matching rates for 17 states will be lower in 2003 than in 2002.[6] The current FMAP rates are based on data from years prior to the recession, placing a number of states in the position of having to fund their Medicaid programs with fewer federal dollars in a fiscally challenging period.

Allowing states to retain the prior year's Medicaid matching rate in years 2002 and 2003 C if the rate otherwise would drop below the prior year's level C coupled with a modest temporary increase in the FMAP could help all states to cope with the current fiscal pressures. This could help them to avert or to lessen the depth of damaging cuts in Medicaid and other basic programs. In particular, such temporary fiscal relief could appreciably lessen the magnitude of Medicaid cuts that states otherwise will feel compelled to implement. On July 25, 2002, the Senate passed by voice vote[7] an amendment to the "Greater Access to Affordable Pharmaceuticals Act" (S. 812) offered by Senators Jay Rockefeller (D-WV) Susan Collins (R-ME) and Ben Nelson (D-NE) that provides fiscal relief to states and temporarily increases Medicaid matching rates. The Senate approved S. 812 on July 31; the measure now proceeds to the House of Representatives for further consideration.

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[6] The 29 states where Medicaid matching rates dropped in 2002 are Alaska, Arkansas, Arizona, Florida, Georgia, Kentucky, Louisiana, Minnesota, Mississippi, Montana, Nebraska, New Mexico, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. The 17 states where FMAPs will drop in 2003 are California, Idaho, Indiana, Kansas, Kentucky, Maine, Michigan, Nebraska, North Dakota, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

[7] Prior to the unanimous consent motion, there was a procedural vote on a point of order that would have blocked consideration of the FMAP amendment. That point of order was rejected by a vote of 75-24 vote, thereby allowing the amendment to be approved.

Description of the Senate-Passed State Fiscal Relief Amendment

The Rockefeller-Collins-Nelson amendment provides temporary fiscal relief to states from April 2002 through September 2003 by allowing any state whose Federal Medical Assistance Percentage (FMAP) is lower than the FMAP for the prior fiscal year to retain the higher rate and by providing a 1.35 percent increase in the Federal Medicaid matching rate for all states. In addition, the bill provides temporary state fiscal relief grants through Title XX of the Social Security Act that could be flexibly used for the same kind of social services programs that are currently supported through Social Services Block Grant funds. The grants would be available to the states through September 30, 2004 and would constitute a funding stream separate from the existing Social Services Block Grant in Title XX of the Social Security Act.

Conclusion

The Medicaid program is based on a federal-state partnership. During this difficult period, the federal government should enhance its role in this partnership and provide some needed fiscal relief to states. A temporary increase in the Federal Medical Assistance Program (FMAP) could help to ensure that low-income children, families, elderly people, and persons with disabilities continue to receive the health care they need. It would also help to ensure that there are sufficient financial resources for hospitals, clinics, nursing homes, doctors, and other providers to continue to offer health care services to low-income Americans.