



Special Report

Washington Research Council

December 13, 2002

BRIEFLY

Medical Assistance is one of the most significant cost drivers in the state budget. The program provides vital life-giving services to the most vulnerable populations. Managing its budget without doing harm is one of the most significant challenges lawmakers will face.

The multifaceted growth in Medical Assistance spending has many complex causes, including increased enrollments, higher rates of utilization, and the introduction of new medical devices, treatment procedures and drug compounds.

The state lacks a comprehensive management information system to provide the information it needs to evaluate the cost effectiveness of the current Medical Assistance program and assess the potential costs and benefits of proposed budget and policy changes. Such a system should be developed.

In the near term, without such information, policymakers must avoid the temptation to focus on discrete service area cost trends, and instead consider the cost-effectiveness within the system as a whole as they develop budget strategies.

The Medical Assistance Challenge

When the State Legislature convenes in January, its primary responsibility will be to adopt a balanced budget for the 2003-2005 Biennium. This will not be an easy task. State budget analysts say that the costs of continuing existing programs will exceed available revenues by roughly \$2 billion.

The Medical Assistance program presents the single largest demand for increased spending from the general fund, nearly \$500 million. In addition, the state faces a \$500 million gap in the Health Services Account, which also provides funding to Medical Assistance.

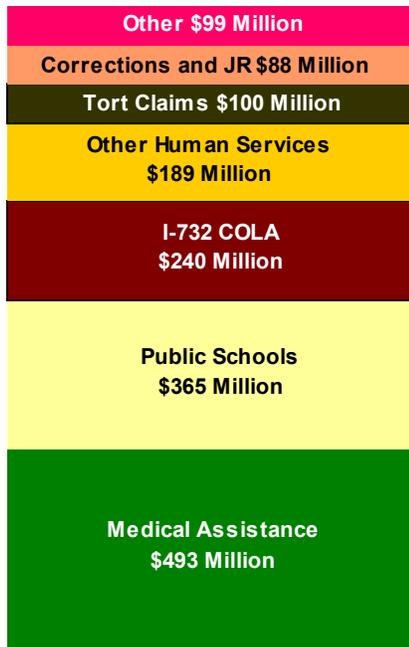
Medical Assistance expenditures are driven up both by increased enrollments and by higher costs per enrollee. Spending in most Medical Assistance categories is growing much faster than the general rate of inflation. Therefore, policymakers will be forced to look carefully at these programs as they attempt to balance the budget without major revenue increases.

Washington is not alone. The Fiscal Survey of the States compiled by the National Association of State Budget Officers concluded that Medical Assistance spending “is the most significant cost issue affecting state budgets.”¹ The Kaiser Commission on Medicaid and the Uninsured notes that while the cost pressures states face with regard to Medical Assistance are also faced by private sector health care programs, the revenue shortfalls brought on by the recession make the problem particularly acute for government: “Although healthcare expenditures are also rising in the private sector, the acceleration of Medicaid spending growth is a serious concern for the federal government and state governments facing a combination of less revenues and increasingly austere budget forecasts.”

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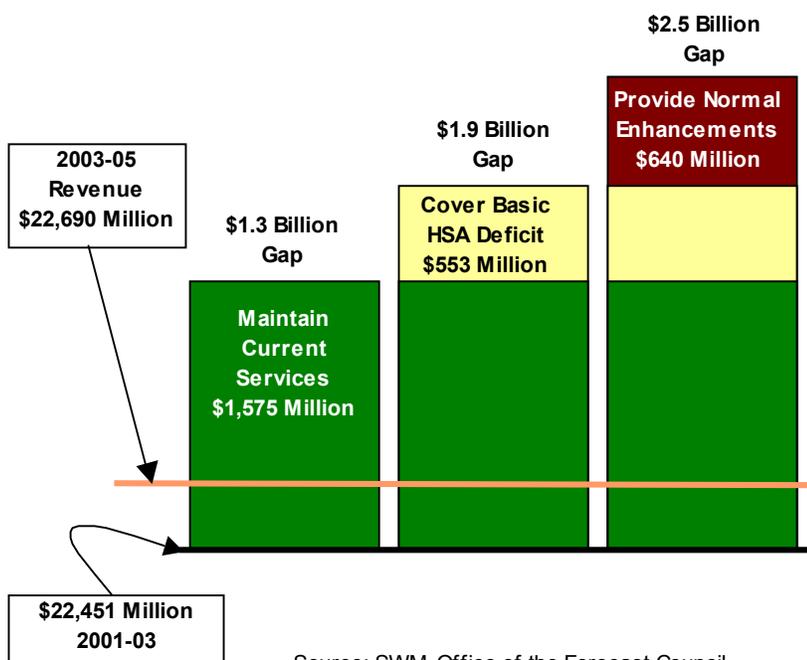
Cost control options have equally complex interactions and consequences in health service areas for the needy. Medical Assistance funds a multitude of health service programs that are interrelated. High costs in one area, such as prescription drugs or managed care may lower costs in other areas, such as hospitalizations. Low costs in some programs, if they're a result of deferred or denied service, can result in higher future treatment costs.

CHART 1
Nearly 1/3 of the 2003-05 Current Services Spending Increase is Due to Medical Assistance



Source: SWM

CHART 2
The Budget Gap is Estimated to Range Between \$2.3 Billion and \$2.5 Billion



Source: SWM, Office of the Forecast Council

Medical Assistance provides vital life-giving services to the most vulnerable populations. Managing its budget without doing harm is one of the most significant challenges lawmakers will face.

The Fiscal Context

In October, the Senate Ways and Means Committee estimated that State General Fund appropriations for the in the 2003-05 biennium would need to exceed 2001-03 appropriations by \$1,575 million in order to continue providing the services currently provided. Thirty-one percent of this increase, \$493 million, is targeted for Medical Assistance. (See Chart 1.) The November revenue forecast puts 2003-05 general fund revenues at \$22,690 million, \$1.3 billion less than the funding needed to maintain current services. (See Chart 2.)

Beyond the general fund, the state faces a \$553 million deficit in the Health Services Account (HSA). Including the anticipated HSA deficit raises the budget gap to \$1.9 billion. Medical Assistance is expected to receive \$723 million from the Health Services Account in 2003-05.

Selected program enhancements could drive the deficit above \$2.5 billion.

A number of the Medical Assistance programs are part of Medicaid, the federal-state partnership that funds medical care for low-income individuals. Each dollar the state spends on Medicaid from the general fund or the Health Services Account is matched by at least one federal dollar.

Many people use Medicaid and Medical Assistance synonymously. However, it is important to understand the difference between the two terms.

What is Medicaid?

First, it is important to understand what Medicaid is and what it is not.

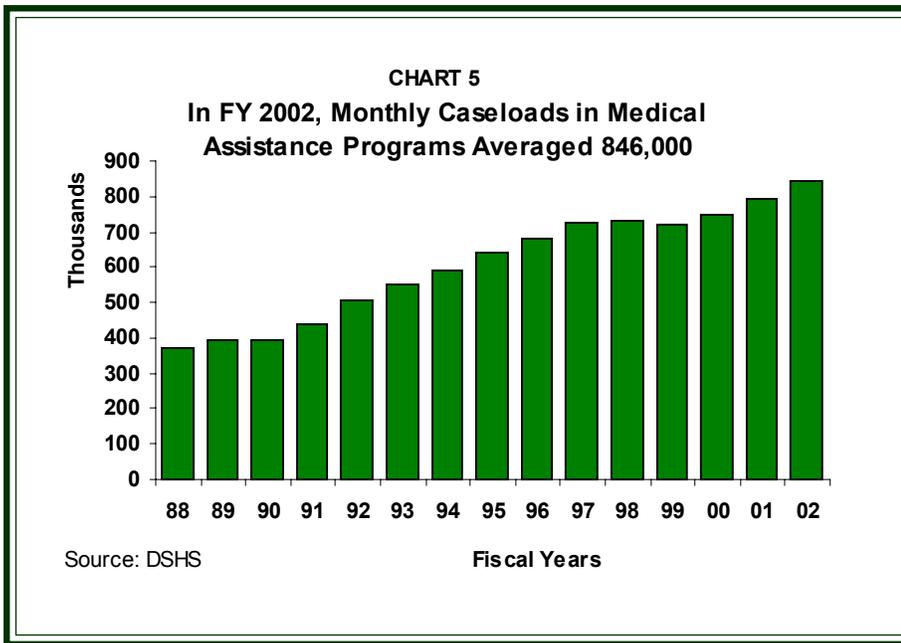
Medicaid is not Medicare. Medicare is a federal health insurance program for people age 65 years or older and certain persons of disability. Medicaid is a means-tested, federal-state shared program-providing health insurance for low-income families, and long-term care services for the elderly and disabled. Medicaid does supplement the Medicare coverage of some low-income seniors.

Medicaid is a source of revenue provided by the federal government to the state in the form of matching funds. Those revenues are used to offset costs in many different state programs providing health care assistance to the poor. Authorized in 1966 by Title XIX of the Social Security Act, Medicaid funds may only be used to offset a portion of state expenditures for a specified list of medical services for the poor. About half the total cost of these services is paid for by the Federal government.

Medicaid is an entitlement program. That means there are no upper limits on the commitment of federal/state resources. Once eligibility is granted, beneficiaries are entitled to receive the program's benefits. Usage and cost of services then drive the total required expenditures. States are not required to participate in Medicaid, but because it enables states to leverage federal funds to assist with the medical needs of the poor, all states have opted in. States that participate in Medicaid must cover several categories of eligible people considered to be "categorically needy" (CN) as shown in Chart 3. States have the option of extending coverage to the categories shown in Chart 4, which includes a "medically needy" (MN) category for those whose income level is too high to meet eligibility requirements, but whose medical expenses have reduced their income to below the state's medically needy income level.

The federal program also mandates provision of certain services, such as inpatient and outpatient hospital care, physician, laboratory and x-ray services, family planning, nurse practitioner and surgical services of a dentist. Many

<p>CHART 3 Medicaid</p>	<p>CHART 4 Medicaid</p>
<p>Groups That MUST Be Covered</p> <ul style="list-style-type: none"> <input type="checkbox"/> Individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996. States have the option to use more liberal criteria. <input type="checkbox"/> Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL). <input type="checkbox"/> Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery and postpartum care). <input type="checkbox"/> Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements that pre-date SSI). <input type="checkbox"/> Recipients of adoption or foster care assistance under Title IV of the Social Security Act. <input type="checkbox"/> Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time). <input type="checkbox"/> All children under age 19, in families with incomes at or below the FPL. <input type="checkbox"/> Certain Medicare beneficiaries. 	<p>Groups That States MAY Cover</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than a state-established percentage of the FPL up to 185% of poverty (the percentage amount is set by each state). <input type="checkbox"/> Institutionalized individuals eligible under a "special income level" (the amount is set by each state-up to 300 percent of the SSI Federal benefit rate). <input type="checkbox"/> Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waiver programs. <input type="checkbox"/> Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL. <input type="checkbox"/> Recipients of state supplementary income payments. <input type="checkbox"/> Certain working and disabled persons with higher family incomes. <input type="checkbox"/> "Medically needy" persons <p>Source: DSHS</p>



other services, such as prescription drugs, rehabilitation and optometric services may be provided at the state's option. Within those broad national guidelines, each state establishes its own eligibility criteria, scope of services and rates of payments. The state is then entitled to receive Medicaid matching funds and, if they meet the state's eligibility criteria, the state's residents are entitled to receive Medicaid services.

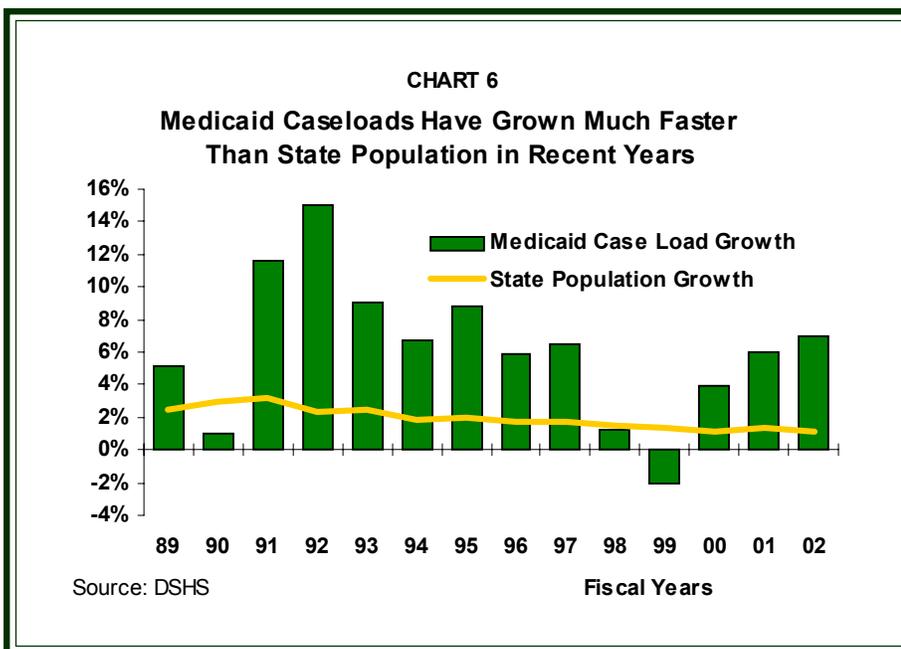
Conceived as a relatively Spartan program, Medicaid coverage was initially limited to doctor and hospital services for families on welfare, and the blind and aged who were well below the Federal Poverty Level. Eligibility for Medicaid coverage was dependent upon

receipt of federally assisted income payments such as welfare or Supplemental Security Income (SSI).

That is no longer the case, and the program is no longer Spartan. In the late 1980's and throughout the 1990's, the federal government increased options and permitted expansions of coverage for Medicaid to various poverty-related groups. As Washington State's Medical Assistance Administration (MAA) has noted, "Washington eagerly grasped each opportunity and soon became a bellwether state experiencing tremendous growth in coverage, clients, and expenditures."²²

As Chart 5 shows, between 1988 and 2002 the number of Washingtonians covered by Medical Assistance grew from 372,000 to 846,000. Since 1990 the percentage growth in numbers of people receiving Medical Assistance coverage has exceeded state population growth in each year except

1998 and 1999, when a number of welfare recipients were mistakenly dropped from Medicaid during the transition from Aid to Families with Dependent Children (AFDC) to Temporary Assistance for Needy Families (TANF). (See Chart 6.)



The vast majority of federal Medicaid dollars are spent through the Department of Social and Health Services where the Medical Assistance Administration Division (MAA) administers the bulk of Medicaid funds. Apart from MAA, the Division receiving the most Medicaid dollars is the Aging and Adult Services Division, which receives about half of its one billion dollar annual budget from Medicaid. Smaller amounts of Medicaid funds

are channeled to Developmental Disabilities and the state-operated Mental Health hospitals, each of which receives less than \$25 million per year in federal matching Medicaid funds.

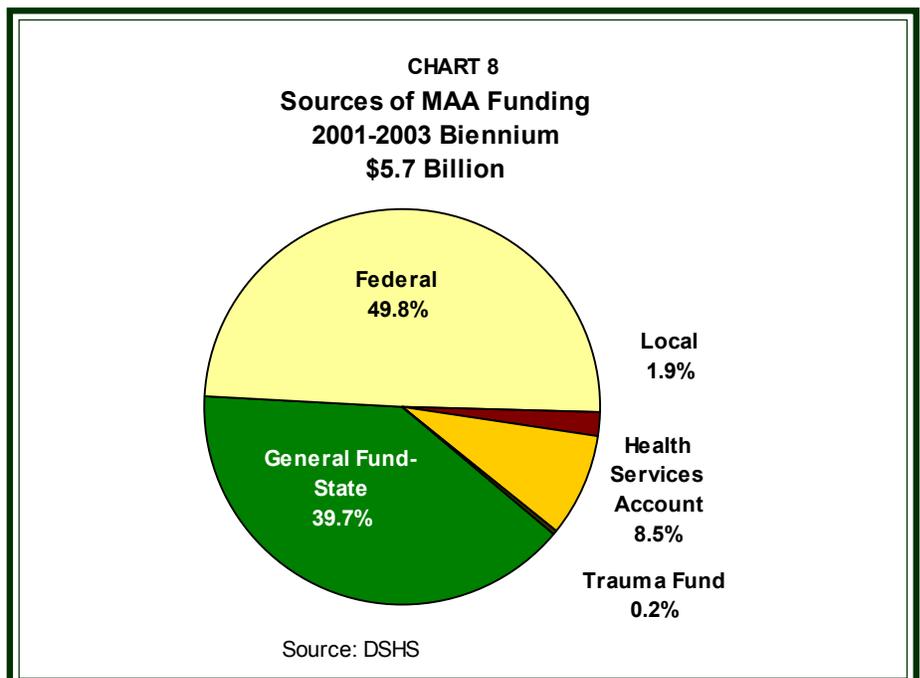
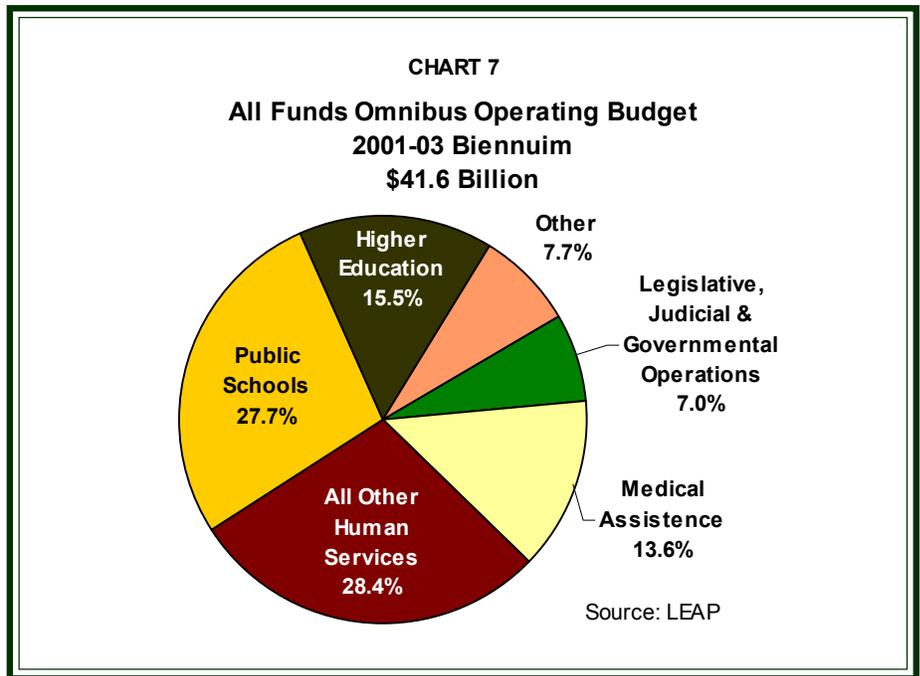
Medical Assistance Administration

For the 2001-2003 biennium, MAA is projected to spend about \$5.7 billion. Medical Assistance expenditures from all sources represent a full 13.6 percent of the state budget. (See Chart 7.)

(Note: The \$5.7 billion figure for MAA expenditures excludes \$622 million in payments made hospitals and nursing homes and then rebated back to the state as part of a scheme to exact extra matching funds from the federal government. See the discussion of ProShare on page 7.)

Funds for MAA programs come from five sources. Two are relatively minor: the Department of Health administers a Trauma Fund, which provides enhanced payments to hospitals for trauma care capped at \$4.6 million per year. Intergovernmental transfers generate about \$115 million per year. The vast majority of the funding, however, comes from the other three sources: federal matching funds, the State General Fund and the Health Services Account. All three of those fund sources are experiencing reductions in anticipated revenues. (See Chart 8.)

Federal Funds: The federal share of Medicaid spending (known as FMAP – The Federal Medical Assistance Percentage) is determined according to a formula that provides a higher match to the poorest states. FMAP can range from a low of 50 percent to a high of 83 percent. The match rate is determined annually based on how the state's per capita income compares to the national average per capita income. Washington's matching rate has ranged from 50 percent to just over 55 percent, but since 1999, the match has been on a downward trend. For the 2001-2003 biennium, the average federal share is estimated to be 50.27 percent.



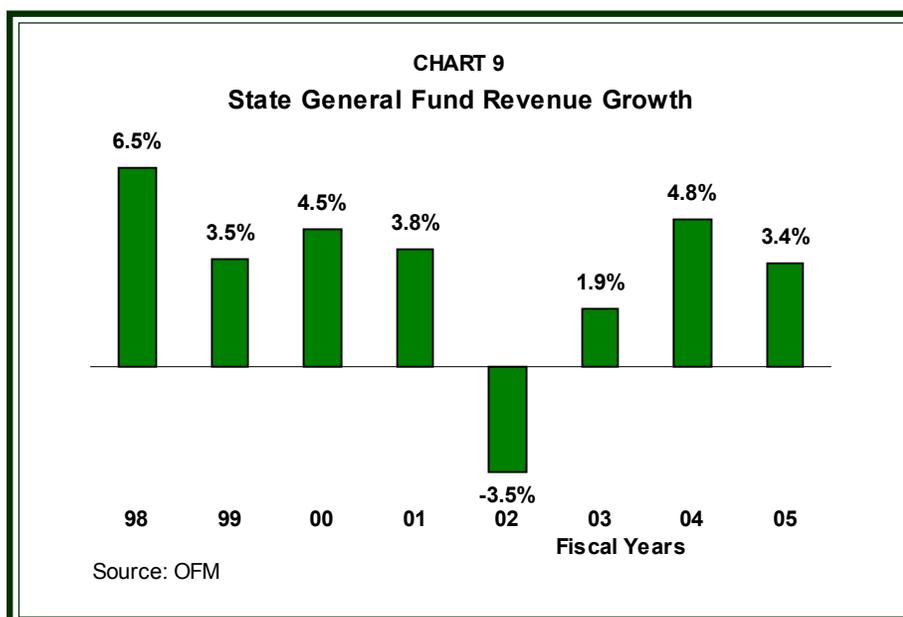
This downward trend results from the stock options received by employees of Microsoft and other high tech firms, which boosted Washington State's per capita income in the late 1990s.

Changes in per capita income affect FMAP with a considerable lag. For example, Medicaid matching rates for fiscal year 2002 are based on state per capita income data for the years 1997, 1998 and 1999. Thus, the high per capita income enjoyed by the state before the "dot com" failures will continue to push down Washington's matching rate for the next several years.

For the 2003-2005 biennium the match will decline to 50.0 percent. The reduced federal match is estimated to cost the state \$23.3 million next biennium - \$11.2 million in FY 2004 and \$12.1 in FY 2005.

State General Fund: Washington State has been hit hard by the general economic decline, which was exacerbated by the impact on the aerospace industry of the terrorist attacks. Consequently, revenues collected for the State General Fund in 2001-2003 are now projected to be \$1.4 billion less than forecast when the biennial budget was adopted. The general economic malaise, coupled with tax policy changes and voter initiatives decreasing the tax base mean that for the first time in over 25 years, actual collections are expected to decline in FY 2002. (See Chart 9.) State economists predict revenues will recover only slowly, with a 1.9 percent increase in 2003, a 4.8 percent increase in 2004, and a 3.4 percent increase in 2005. Those growth rates are much less than the projected growth rates in health care system spending.

Health Services Account: The Health Services Account (HSA) is a dedicated fund originally created in 1993 as a vehicle to fund the State's Basic Health Plan coverage for the "working poor," i.e. for those who could not qualify for Medicaid but lacked access to affordable health care. The account was later expanded as new revenue sources like the Tobacco Settlement money became available and legislators availed themselves of an opportunity to avoid Initiative 601's expenditure limit as it applies to the General Fund. The state funded new medical assistance programs covering children from families with incomes between 200 percent and 250 percent of the federal poverty level and breast and cervical cancer patients from the HSA.

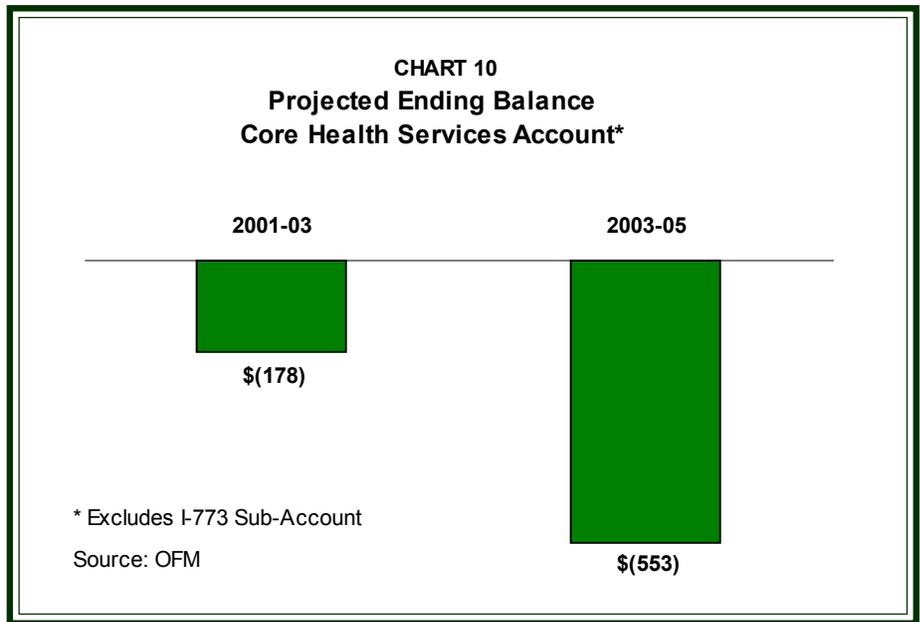


In some cases, the legislature transferred existing funding responsibility for programs from the General Fund to the Health Services Account. For example, effective October 1, 2002, the Department of Social and Health Services Medical Assistance no longer offered medical coverage for undocumented children and some non-citizen immigrants who have been in the United States less than 5 years. Coverage instead is available through the state-subsidized Basic Health Plan. That transfer brought with it anticipated savings because BHP does not provide dental and vision care, and

unlike Medical Assistance, the BHP requires some recipient cost sharing.

In other cases, the Legislature transferred money from the Health Services Account to the General Fund. One hundred fifty million that the state expected to receive from the Nursing Home Proportionate Share program (ProShare, see the discussion below) was earmarked to help balance the General Fund budget.

However, the Legislature assumed that the dedicated fund would have ample revenues to meet those funding obligations. This turns out not to be the case. Instead, the HSA has a large deficit. (See Chart 10.)



The account was hit particularly hard by the federal government’s decision on ProShare payments. ProShare is the mechanism Washington State designed to exploit a loophole in federal law in order to access additional federal Medicaid dollars. Medicaid reimbursement levels are usually less than would be allowed for Medicare reimbursements. Federal law permits states to pay hospitals and nursing homes as much as Medicare would have paid.

Under the ProShare scheme, the hospitals and nursing homes billed the state at the Medicare rate; the state claimed the matching funds and then required the billing entity to refund to the state most of the difference between the standard Medicaid and Medicare rates. Washington was one of many states that used Medicaid’s upper payment limit to leverage funds that were then used to offset normal state Medicaid costs rather than to provide increased Medicaid coverage.

Despite ample warning that the federal government fully intended to close this loophole, the Legislature relied on ProShare funds to finance HSA programs. After intense negotiations with federal regulators, state officials ultimately settled for \$530 million less than they’d anticipated receiving for the 2001-03 and 2003-05 biennia. OFM estimates the shortfall in the HSA for this biennium will be \$178 million, with an additional shortfall of \$375 million next biennium. At this time, OFM believes the shortfall can be “underwritten” by Initiative 773 revenues.

Initiative 773, approved by voters in November 2001, increased the tax on cigarettes and tobacco products and directed the new revenues to the HSA. A small portion of the money was targeted to increase spending on prevention of tobacco use and to provide funding for other programs to improve the health of low income persons. Ninety percent of the increased revenues were dedicated to expand access to Washington State’s Basic Health Plan beyond 125,000 enrollees.

To date the Legislature has been unable to increase enrollments in the Basic Health Plan to a point that would permit spending these revenues.

CHART 11
Balance Sheet
Initiative 773 Sub-Account
of the Health Services Account
(millions of dollars)

	2001-03	2003-05
Beginning Balance	-	125
Taxes		
Cigarette	203	260
Tobacco Products	22	35
Transfers		
Prevention and Control Account	(22)	(29)
Unrestricted Health Services Account	(26)	(32)
Water Quality	(6)	(8)
VRDE	(6)	(8)
Net Revenues	164	218
Expenditures		
2001-03	39	-
2003-05 as per I-773	-	201
Ending Balance	125	142

Source: OFM

The I-773 revenues are held within a separate sub-account within the HSA. The “Core” Health Services Account excludes the I-773 revenues. State law requires that no fund run a negative balance. However, the HSA is technically one fund, and the constraint against negative fund balances applies to the HSA overall but not to the core HSA or the I-773 sub-account individually. So as long as ample Initiative 773 revenues are in the HSA, the fund is not in a deficit and the state may be able to run other HSA-funded programs in the red.

Chart 11 the source of revenues and projected collections for the I-773 sub-account of the HSA.

Where does the money go?

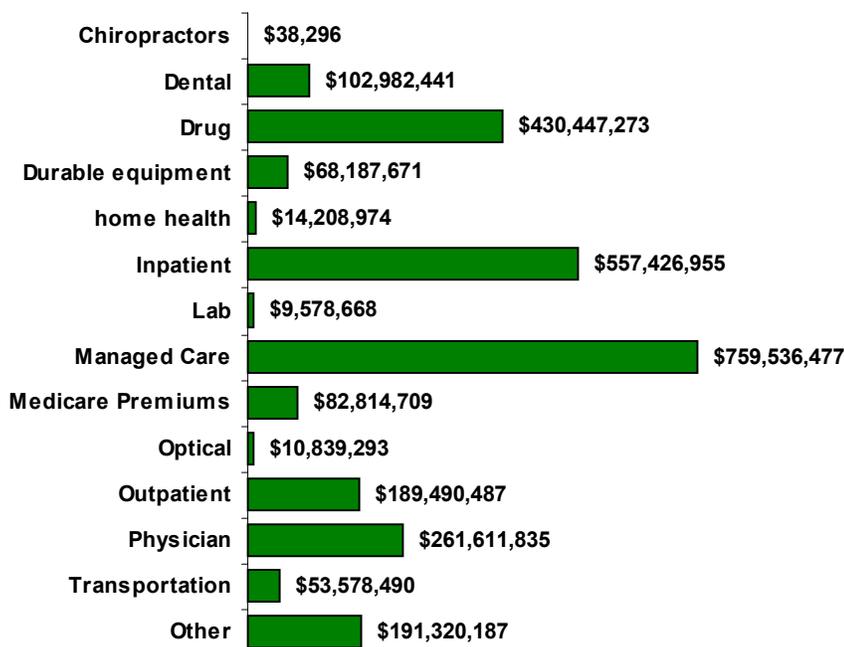
Medical Assistance expenditures can be broken down alternately by services (things like hospital care, drugs, and medical equipment) or by categories (programs or groups of clients).

In 2002, MAA spent \$2.7 billion on 14 categories of services. The four largest services were Managed Care Premiums at \$760 million; Hospital Expenditures at \$747 million (\$557 million for inpatient services and about \$189 million for outpatient services); Drugs at \$430 million; and Physicians at \$262 million. (See Chart 12.) Together, those services accounted for more than 80 percent of all medical assistance expenditures. (See Chart 13.)

Categories of clients include:

Categorically Needy TANF:
This mandatory Medicaid category includes families that are enrolled in Temporary Aid to Needy Families program (TANF) as well as those not enrolled in TANF who meet the requirements of its predecessor

CHART 12
MAA Services in FY 2002 - All Funds Dollars



Source: DSHS

program, Aid to Families with Dependent Children.

Categorically Needy Aged:

This mandatory Medicaid category includes aged individuals who qualify for Supplemental Security Income (SSI) payments from the Social Security Administration.

Medically Needy Aged:

This optional Medicaid category is similar to CN Aged, but with a higher income and resource limits.

Categorically Needy Blind or Disabled:

This mandatory Medicaid category includes non-aged SSI recipients.

Medically Needy Blind and Disabled:

This optional Medicaid category is similar to CN Blind and Disabled, but with higher income and resource limits.

Categorically Needy Other Kids:

This mandatory Medicaid category covers children from families whose incomes are below 200 percent of the federal poverty level who are not covered under another Categorically Needy category. The terms of Washington's "Healthy Options" waiver (see page 16) increased the income threshold from 133 percent to 200 percent of FPL and the age limit from 6 years to 19 years.

Categorically Needy Pregnant Women:

This mandatory Medicaid category covers pregnant women with income at or below 185 percent of the federal poverty level. The terms of Washington's "Healthy Options" waiver increased the income threshold from 133 percent to 185 percent of FPL.

Medically Needy Other:

This is a catchall category.

Categorically Needy Breast and Cervical Cancer:

This program covers women with breast and cervical cancer without other health insurance whose income is below 200 percent of FPL.

Categorically Needy Medicaid Buy In:

This program, also known as Healthcare for Workers with Disabilities, allows people with disabilities who fail the earnings test for Medicaid eligibility because they work to buy into the Medicaid program. The program is intended to remove a disincentive to employ disabled persons.

State Child Care Insurance Program (SCHIP):

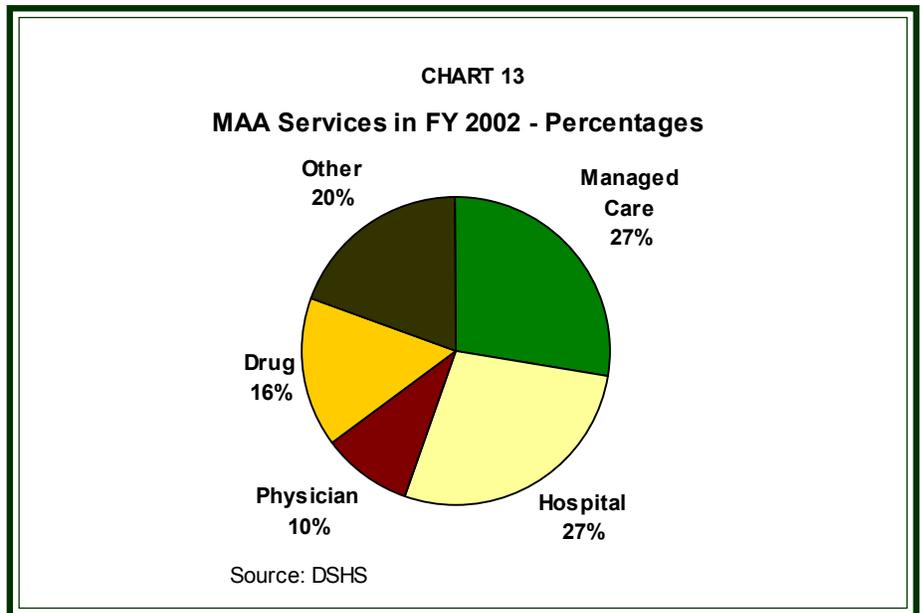
This relatively new program covers children under the age of with incomes between 200 percent and 250 percent of FPL.

Qualified Medicare Beneficiary:

This program pays Medicare premiums, copayments, and deductibles for individuals with incomes too high to qualify for the CN or MN Aged programs but below the federal poverty level.

Alcohol and Drug Addiction Treatment and Support Act:

This category includes persons who are unemployable due to alcoholism or drug addiction



General Assistance-Unemployable (GA-U): GA-U is a state-funded welfare program serving individuals who do not qualify for TANF.

State Only Less than 18 Years Old: This state-funded program, which was phased out in October 2002, provided health care for alien children under the age of 18.

Medically Indigent: This state-only program covers certain emergency hospital services to medically needy individuals not eligible for other medical assistance programs.

Refugee Assistance: The refugee program is 100 percent federally funded

Indian Health: The federal government reimburses Medical Assistance for 100 percent of the cost of the Indian Health Service.

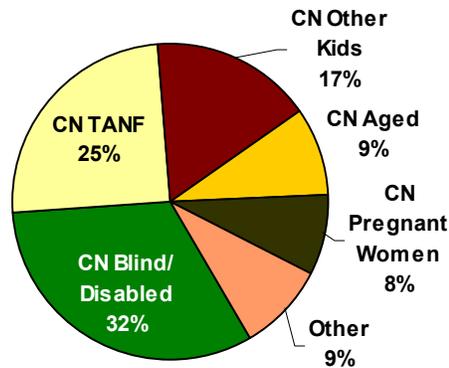
Family Planning: Programs in this category provide family planning services to low income women for 10 months after they graduate from the CN Pregnant Women (Family Planning Extension) and pre-pregnancy family planning services to certain low income men and women (Take Charge).

Supplemental Medical Insurance: This category encompasses several programs that pay Medicare Supplemental Medical Insurance premiums for individuals with incomes too high to qualify for the Qualified Medicare Beneficiary program.

Chart 14 shows the average number of individuals eligible for services monthly in 2002 for 15 Medical Assistance programs. The CN Kids program was the largest, with nearly 320,000, followed by TANF, 272,000, Categorically Needy Blind and Disabled, 115,000, and Categorically Needy Aged, 53,000. Together these four categories accounted for 90 percent of the 846,000 total.

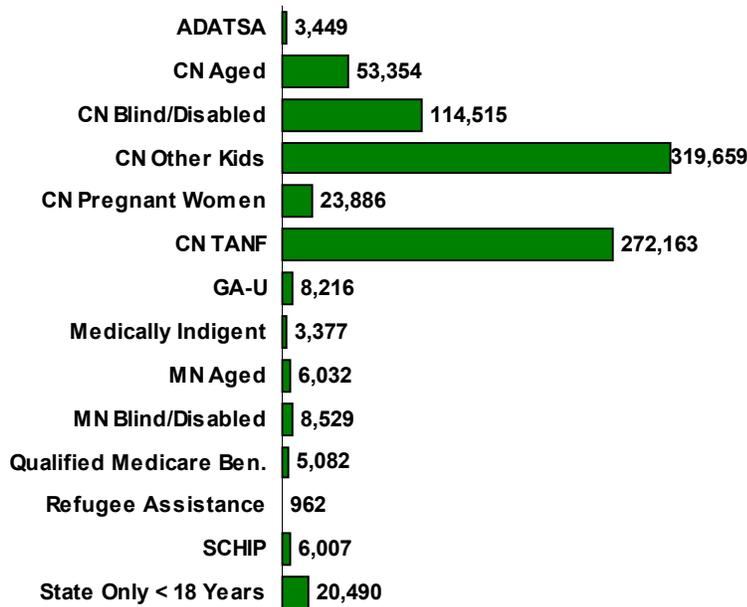
As will be discussed below, spending per capita varies considerably across these programs. As a

CHART 14
Distribution of MAA Expenditures by Category FY 2002



Source: OFM

CHART 15
Average Monthly Enrollments in FY 2002



Source: DSHS

result, expenditures are distributed somewhat differently than caseloads. Chart 15 shows the distribution of expenditures across these programs for FY 2002. In terms of expenditures, Categorically Needy Blind and Disabled was the largest of the programs, accounting for 32 percent of spending for the 14 programs. CN TANF ranked second, at 25 percent, while CN Other Kids was third, at 17 percent.

At its simplest level, spending increases in programs funded by Medicaid dollars can generally be attributed to two basic causes: 1) increased number of cases, or 2) increased costs per case. Let's look first at the increases in caseload.

Increased Caseloads

Medical Assistance is designed to provide medical coverage to the poor; so one predictor of Medical Assistance caseloads should be the percent of poverty population in the state. In 2001, 10.7 percent of Washington's population was at or below the federal poverty level, ranking it 24th among the states. However, as shown in Chart 16, 13.7 percent of Washington's population was enrolled in Medical Assistance in 2001, ranking Washington 17th among the states.

Between 1981 and 2001, Washington State experienced a 41 percent increase in total state population. In the same twenty-year time period, Medical Assistance caseloads grew 168 percent. Much of that growth was a direct result of deliberate policy choices.

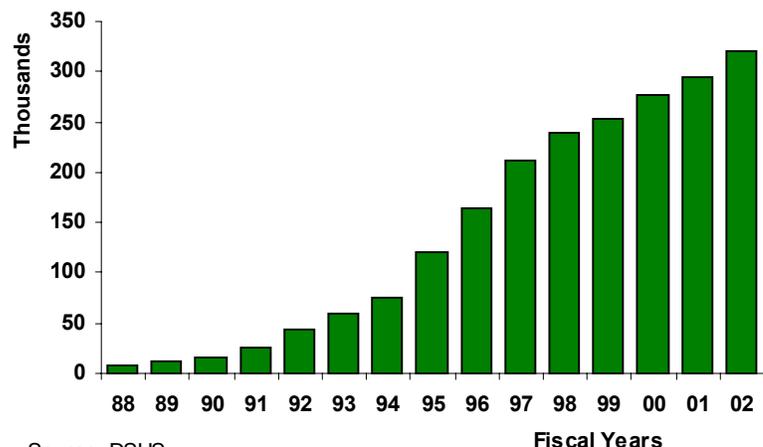
Children provide the most dramatic example. When the Federal government allowed states to offer coverage for children in families previously ineligible for Medicaid but whose parents were unable to provide health care insurance for

CHART 16
Percent of Population in Medicaid
2001

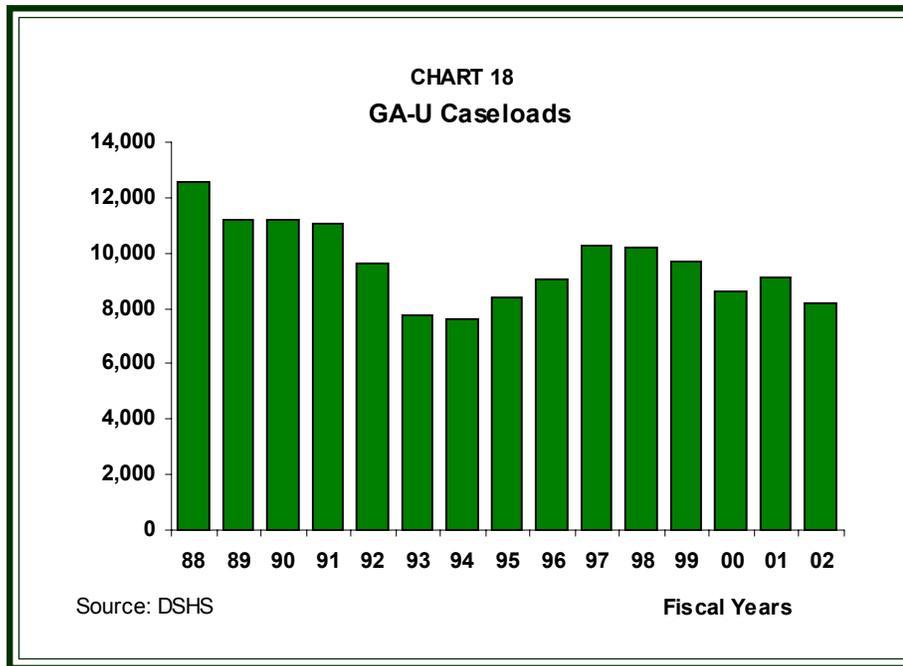
State	Percent	Rank	State	Percent	Rank
Tennessee	24.6%	1	Nebraska	12.1%	26
Mississippi	20.3%	2	Michigan	12.0%	27
New Mexico	18.2%	3	Illinois	12.0%	28
Louisiana	17.6%	4	South Dakota	11.5%	29
California	16.9%	5	Oregon	11.5%	30
New York	16.6%	6	Arizona	11.4%	31
South Carolina	16.3%	7	Florida	11.2%	32
Rhode Island	16.0%	8	Indiana	10.8%	33
Kentucky	15.9%	9	Idaho	10.8%	34
Vermont	15.8%	10	Connecticut	10.7%	35
Massachusetts	15.5%	11	Minnesota	10.5%	36
West Virginia	15.5%	12	Wisconsin	10.3%	37
Missouri	15.4%	13	Maryland	10.2%	38
Arkansas	15.1%	14	New Jersey	9.8%	39
Maine	14.7%	15	Texas	9.4%	40
Oklahoma	13.8%	16	Wyoming	9.3%	41
Washington	13.7%	17	Montana	8.4%	42
Hawaii	13.7%	18	Iowa	8.3%	43
Alabama	13.7%	19	Kansas	7.8%	44
Alaska	13.5%	20	North Dakota	7.4%	45
Delaware	13.1%	21	Colorado	7.0%	46
Georgia	12.9%	22	Virginia	7.0%	47
Ohio	12.3%	23	Nevada	6.7%	48
North Carolina	12.3%	24	Utah	6.5%	49
Pennsylvania	12.2%	25	New Hampshire	6.4%	50
United States	13.0%				

Source: Kaiser Commission on Medicaid and the Uninsured; U. S. Census

CHART 17
Categorically Needy Other Children



Source: DSHS



them, Washington State availed itself of that opportunity. In 1996, the federal government, acting on the belief that health care coverage for children was cost effective policy and in the long-term best interest of all, offered a 90 percent match to states for outreach to families in order to increase enrollment of children in Medicaid, the state again acted. As Chart 17 demonstrates, this outreach was effective.

As shown by Chart 18, policy choices can also drive caseloads down. During the budget crises of the early 1990's, the Legislature chose to restrict access to the GA-U program. Consequently that program's caseload declined from 11,100 in 1991 to 7,600 in 1994.

Historically, however, decisions to reduce access to Medical Assistance programs are far more rare than policy choices that increase access. Some of the policy choices that drove major expansions of Medical Assistance coverage in Washington State are detailed in the MAA Strategic Plan as follows:

- 1989: Children to age 8 up to 100 percent of the Federal Poverty Level (FPL)
Pregnant women up to 185 percent of FPL
- 1990: Children aged 1 to 5, up to 133 percent of FPL
- 1991: Insurance coverage for certain AIDS patients
- 1992: Children to age 19, up to 100 percent of FPL
- 1993: Healthy Options (Medicaid Managed Care)
- 1994: Children to age 19 up to 200 percent of FPL
- 2000: SCHIP program created to cover children up to age 19 between 200 percent and 250 percent of FPL
- 2001: Family planning for men and women up to 200 percent of FPL (Take Charge)
- 2002: Healthcare for Workers with Disabilities (HWD) up to 220 percent of FPL

Additionally, the Legislature chose to add Medical Assistance coverage for Breast and Cervical Cancer beginning in 2002. These policy choices explain the patterns seen in Chart 6.

But policy choices are not the only drivers of increased caseloads. Economic, Demographic and Technological changes also influence caseload growth.

Economic performance directly impacts Medical Assistance client eligibility. As the unemployment rate rises, so does the demand for state-funded health care services. Anecdotal data suggests that the current economic downturn has caused increases in the number of unemployed persons seeking health care. Higher insurance premiums and lower profit margins for business appear to be causing business to reduce or, in some cases, eliminate health care coverage for their employees. Additionally, the shift from a manufacturing economy to a service-based economy influences caseload growth. The smaller the business, and the lower the wage rate, the less likely the employer will be able to offer affordable health insurance for workers. A decline in the number of people with private health insurance results in greater eligibility for Medical Assistance coverage.

The combination of demographic changes and technological advancements means that there is an increased proportion of elderly and disabled in our population. They tend to use more services at higher costs. Chart 19 shows the increase in the proportion of population over the age of 85 in Washington State. Improvements in medical care also mean that more people survive longer with diseases or disabilities that require ongoing medical services. And as baby-boomers age, they are more apt to qualify for Medical Assistance and need long term care.

Those factors put upward pressure on Medical Assistance caseloads. Chart 20 shows that, among the 44 states for which the Kaiser Commission on Medicaid and the Uninsured collected information, Washington had the 5th highest percentage increase in the Medical Assistance enrollment of Aged and Disabled persons between June 1997 and December 2001.³

CHART 19
Share of Washington's Population
Age Eighty-Five and Over

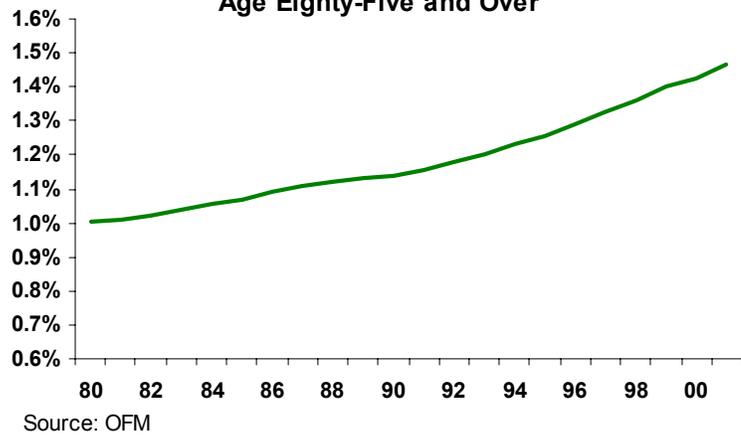


CHART 20
Change in Aged and Disabled Medicaid
Enrollment June 1997 to December 2001

State	Percent	Rank	State	Percent	Rank
Alabama	14%	15	Missouri	17%	10
Alaska	29%	3	Nebraska	8%	23
Arizona	36%	2	Nevada	38%	1
Arkansas	3%	36	New Hampshire	2%	38
California	11%	19	New Jersey	1%	41
Colorado	4%	33	New Mexico	7%	26
Connecticut	8%	24	New York	6%	28
Delaware	28%	4	North Carolina	14%	14
Florida	19%	7	North Dakota	4%	34
Georgia	6%	29	Ohio	1%	40
Hawaii	12%	16	Oklahoma	14%	13
Idaho	19%	8	Oregon	20%	6
Illinois	2%	37	Rhode Island	0%	42
Indiana	17%	9	South Carolina	8%	25
Kansas	10%	21	South Dakota	-1%	44
Kentucky	11%	18	Texas	1%	39
Louisiana	4%	32	Utah	17%	11
Maine	10%	22	Vermont	6%	30
Maryland	3%	35	Virginia	4%	31
Michigan	7%	27	Washington	26%	5
Minnesota	15%	12	Wisconsin	-1%	43
Mississippi	11%	20	Wyoming	11%	17

Source: Kaiser Commission on Medicaid and the Uninsured

Administrative practices can also impact caseloads. DSHS and Legislative staff point out that the state has made Medical Assistance children's programs for the non-disabled very "user friendly." Enrollment can be accomplished by phone with only a self-declaration of income. No one checks the veracity of the self-declarations. Once signed up, the children receive benefits for a year whether or not their family income level changes. Some legislators argue that program audits would likely result in caseload reductions if adherence to the means test (income as a percentage Federal Poverty Level) were enforced.

The above combination of factors has caused exponential growth in the number of Medical Assistance beneficiaries. Caseloads were only just a few thousand in the program's first five years. By 1990 caseloads had reached 400,000. Now Medical Assistance covers nearly a million Washington residents. Medical Assistance pays for more than 40 percent of the births in the state and Medical Assistance covers one in every three children.

Increased Costs Per Case

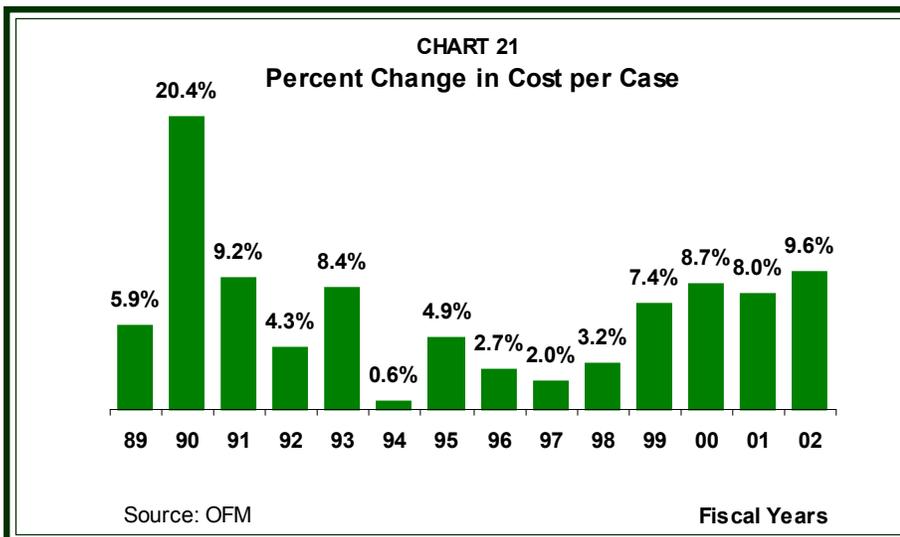


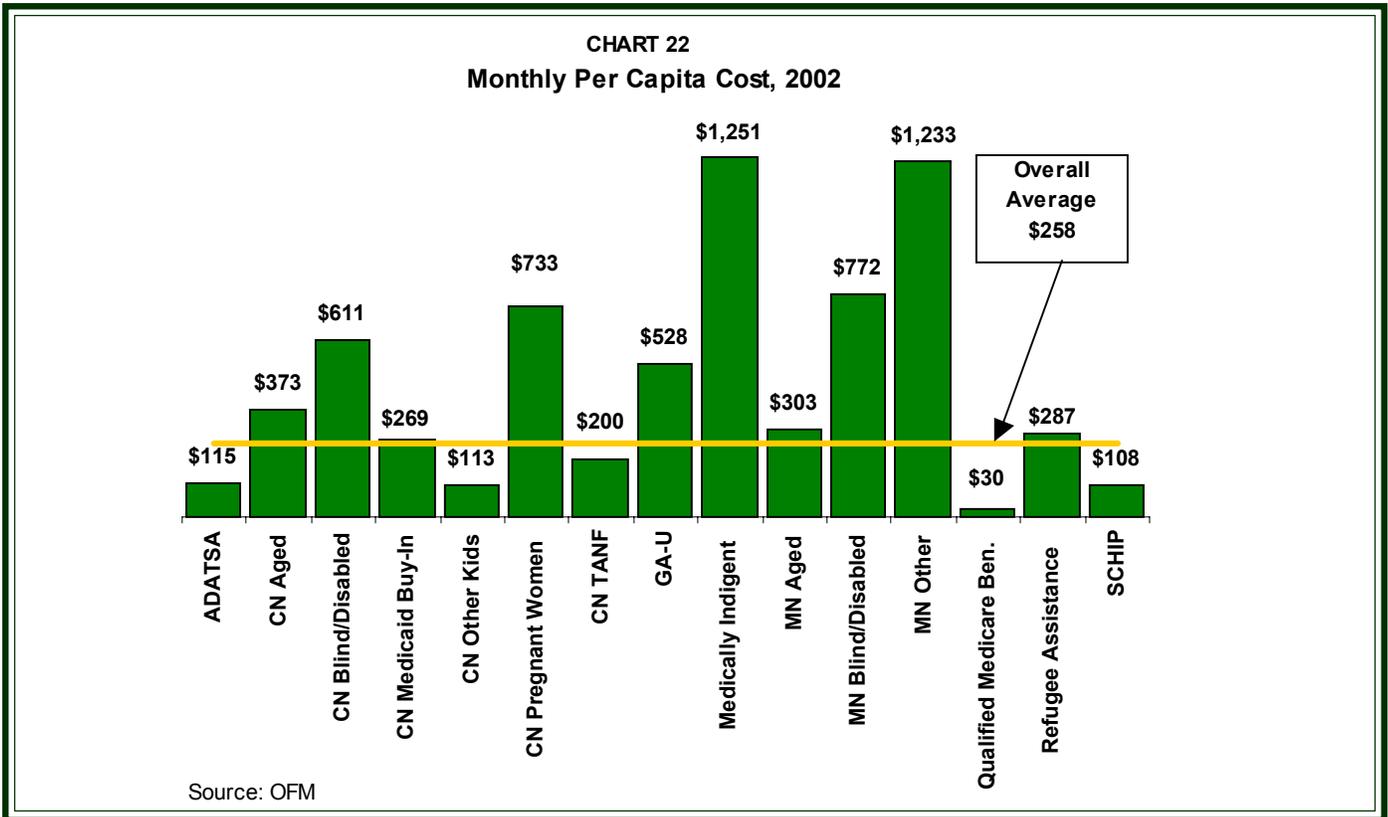
Chart 21 shows the annual percentage increase in the cost per case in Medical Assistance for FY 1989 to FY 2002. Per Capita costs rose phenomenally in the early 1990s (including a 20.4 percent in 1990!). The mid 1990s saw much slower increases, but in recent years the rate of increase has accelerated.

Sorting out the causes of these increases is difficult. The readily available data simply tell us how much is being spent on various broad classes of services for various categories of clients. There is no measure of the quantities of services provided and no measure of the

outcomes. One cannot tell from the data whether an increase in per capita expenditure reflects simply an increase in cost or rather an increase in services provided to clients. And one cannot tell whether spending has improved health.

One complication is that the mix of persons served by the medical assistance program changes over time. Different groups of Medical Assistance enrollees use different services and have different service utilization rates. Children as a group, for example, are low cost beneficiaries of Medical Assistance. The elderly and persons of disability tend to be higher cost groups to cover.

As shown in Chart 22, the average per capita monthly cost across all programs was \$237 in FY 2001. The main program serving children, CN Other Kids, cost \$109 per capita per month, less than half of the overall average. On the other hand, the Categorically Needy Blind and Disabled Category cost, \$532, more than twice the overall average. The rapid increase in the number of children served certainly restrained the increase in the

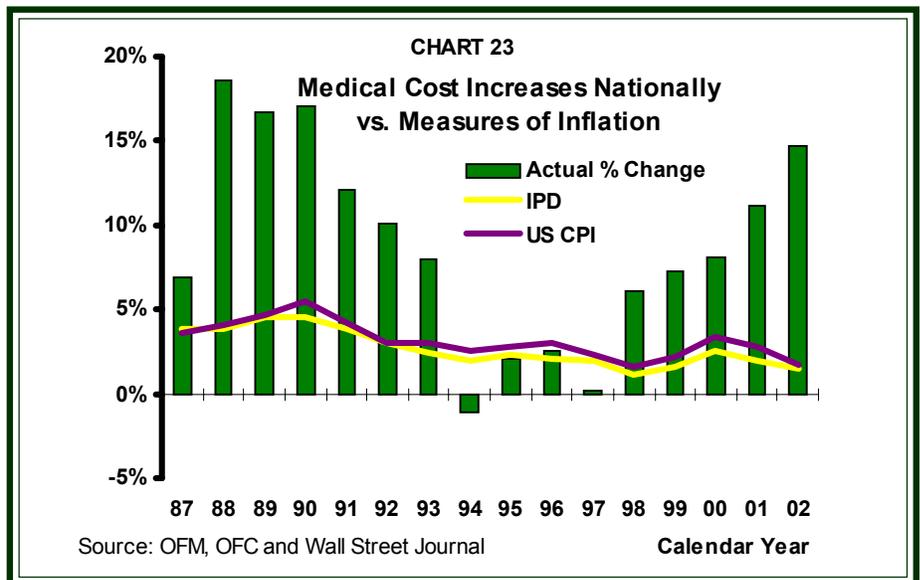


overall per capita cost for the medical assistance program, even as it added to the total cost.

Even within programs, the mix of individuals may change over time in ways that the program data do not capture.

A major factor in the increase in per capita costs of the program is the increase in medical costs in general. National data developed by the Office of Financial Management show that the rate of growth in medical costs greatly exceeded general rates of inflation during the late 1980s and early 1990s. During 1994 to 1997 period medical increases were generally less than inflation. But since 1998 medical costs have again been increasing more rapidly. (See Chart 23.)

Washington's experience of increasing per capital Medical Assistance costs generally accords with national trends. A report done for The Henry J. Kaiser Family Foundation concludes that states are under pressure to increase Medical Assistance spending because of high medical inflation rates, demands for higher provider payment rates, increased costs for prescription drugs, expansion of community-based long term care and increased enrollment.⁴



The National Conference of State Legislatures (NCSL) attributes the per capita expenditure growth to a similar list of factors, including demographic trends, high-priced new technology and new medical procedures, labor costs, economic cycles and general economic theory that “almost guarantees that health cost inflation (including Medical Assistance) generally outpaces inflation,”⁵ but NCSL maintains that three fourths of the projected increases in Medical Assistance will be due to increased costs of care for the elderly and disabled. Although there is rising enrollment in those categories, more than half of the Medical Assistance expenditure increase is expected to result from higher per capita expenditures for the elderly and disabled.

Managed Care Trends

The Medical Assistance Administration administers a variety of health care services paid for in part by Medicaid dollars. For the most part, MAA breaks expenditures into discreet service areas, such as inpatient and outpatient hospital, physician, and prescription drugs. MAA also administers a managed care program, which for accounting purposes is considered a service, but in actuality it is a mode for delivery of services. Payments for Managed Care ultimately buy hospital and physician care, prescription drugs and other medical services. So ultimately cost trends in the other service areas influence the cost of managed care.

Before examining the trends in Medical Assistance costs for health services, it is important to clarify the difference between Managed Care and Fee-for-Service programs.

“Fee for service” programs require payment for each service received. Individuals may choose their health care provider contingent only on the provider’s willingness to accept the level of reimbursement allowed by Medical Assistance. The individual, then, is able to determine which services to buy from whom. Approximately 50 percent of Medical Assistance recipients are enrolled in fee-for-service plans.⁶ This is up from 40 percent in 1996-1999. Some analysts contend that because fee-for-service patients do not have a central point of coordination for their health care needs, an opportunity may exist to improve health outcomes and reduce costs for at least some members of this population by providing case management services. Insert pie chart of services

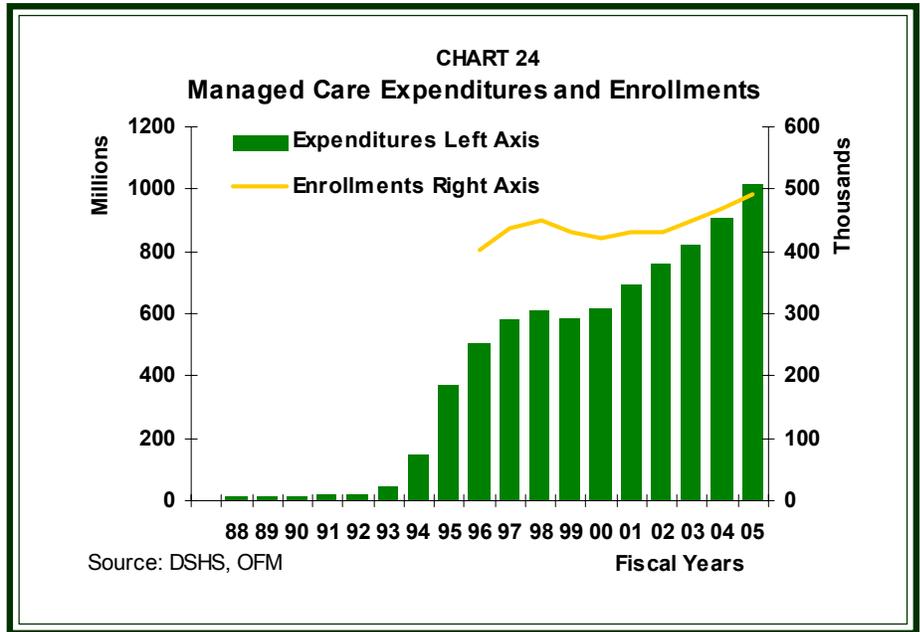
Fifty percent of individuals receiving health care through MAA in FY 2002 were enrolled in managed care plans and they accounted for 21.5 percent of all state MAA expenditures. Four categories of recipients are placed in managed care, CN Kids, CN TANF, CN Pregnant women, and SCHIP. The elderly and disabled, which NCSL have identified as the source of three quarters of future expenditure increases, are not in managed care.

Managed Care programs are sometimes called “capitated plans.” Providers of these plans are paid a fixed (capitated) amount for each individual enrolled in the plan regardless of the services utilized by the beneficiary. A health professional, then, acts as a central coordinator of services, determining which services are appropriate to meet an individual’s needs.

Nationally, managed care is largely credited with helping slow the rate of expenditure increase for Medical Assistance during the mid to late 1990s. But in the last few years, providers have resisted reduced payment rates and

left the Medical Assistance program, forcing states to raise rates in order to maintain the participation of other providers.

Washington Medical Assistance began its big push into managed care in 1993. The managed care program, called Healthy Options, operates under a waiver from standard Medicaid regulations under Section 1915 of the Social Security Act. Healthy Options enrolls clients from the CN TANF, CN Pregnant Women, CN Other Kids, and the State Children’s Health Insurance Program. Healthy Options By 1998 Healthy Options enrollments reached 450,000 (60 percent of total Medical Assistance enrollments) and expenditures reached \$615 million. (See Chart 24.)



In addition to provider pressure on managed care, there has been considerable public pressure to loosen the controls. This has become particularly apparent in the utilization of services. For example, some of the increase in use of hospital services is apparently a result of loosened restrictions in managed care. “It is clear... that managed care’s ability to constrain payment rates for and use of hospital services has diminished.”⁷

Analysts now point to a “managed care backlash” and warn that managed care savings have already been achieved or are not occurring as expected.⁸ The trends in Washington are consistent with those national analyses. A recent report from the Health Policy Center of the Urban Institute⁹ states that Washington had a history of “relatively generous rates” for managed care, “however, a new round of competitive bidding in 2001 led to only a 3 percent Medical Assistance rate increase. Two major plans withdrew, forcing the state to increase rates by 8 percent in 2002 to retain the rest.” Consequently, DSHS estimates now show the cost of managed care on a steep upward trend, climbing from a 4.2 percent rate of growth in the last year of this biennium (2003) to 6.4 percent in FY 2004 and 10.2 percent in FY 2005. The result is a 14.1 percent projected increase in MAA managed care expenditures next biennium.

DSHS staff point out that the goal of managed care plans is to coordinate services and thus improve quality and cost-effectiveness of care. The oft-heard criticism, however, is that managed care may set up barriers to access and thus save money by reducing the quality of care. National health policy analysts say those concerns have recently led to a relaxation of managed care plans contributing to increased utilization of services and higher expenditures throughout the health care system. The American Hospital Association annual survey data bears that out, indicating a sharp increase in both outpatient and inpatient utilization in 2000 and continuing in 2001, which analysts suggest is partly driven by a short-term shift away from tightly managed care.¹⁰

Hospitals

CHART 25
Hospital Adjusted Expenses per Inpatient Day,
2000

Rank	State	\$	Rank	State	\$
1	Washington	1511	26	South Carolina	1101
2	Alaska	1495	27	Hawaii	1088
3	Massachusetts	1467	28	Pennsylvania	1080
4	Oregon	1461	29	Tennessee	1078
5	California	1438	30	Louisiana	1075
6	New Mexico	1388	31	North Carolina	1061
7	Utah	1375	32	Virginia	1057
8	Connecticut	1373	33	Wisconsin	1055
9	Maryland	1315	34	Oklahoma	1031
10	Rhode Island	1313	35	Idaho	1003
11	Arizona	1311	36	Alabama	980
12	Delaware	1311	37	Georgia	978
12	New Jersey	1299	38	Kentucky	929
14	Nevada	1285	39	Arkansas	908
15	Colorado	1280	40	Minnesota	899
16	Illinois	1278	41	Vermont	888
17	Texas	1274	42	West Virginia	844
18	Michigan	1211	43	Kansas	837
19	New Hampshire	1201	44	North Dakota	747
20	Ohio	1198	45	Nebraska	743
21	Missouri	1185	46	Iowa	740
22	Florida	1161	47	Mississippi	719
23	Maine	1148	48	Wyoming	677
24	Indiana	1132	49	Montana	579
25	New York	1118	50	South Dakota	476
	United States	1149			

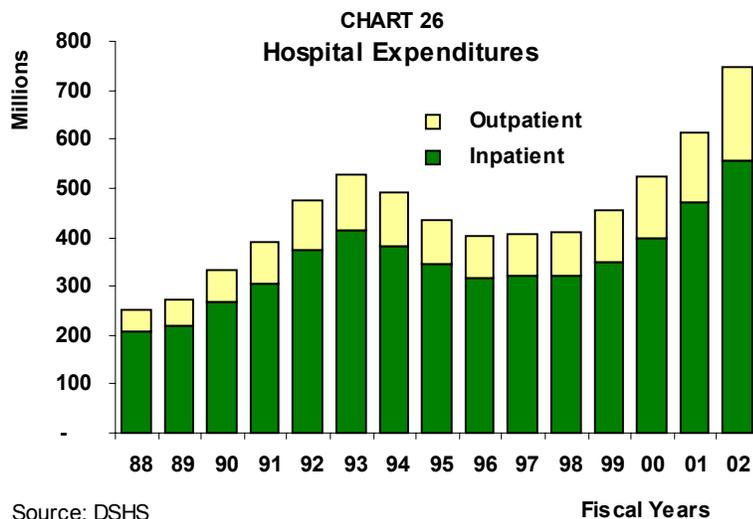
Source: Kaiser Family Foundation, American Hospital Association

At \$1511 per day, The Kaiser Foundation reports that for the year 2000 Washington had the highest inpatient hospital costs of any state. Only the District of Columbia ranked higher (by one dollar per day). The national average is \$1149 per day.¹¹ (See Chart 25.) We were unable to find data to explain why hospital costs are comparatively so high in Washington.

Some analysts speculate that the high cost per day is because Washington does a better job of limiting the number of inpatient days per procedure, i.e. patients are moved out of the hospital more quickly than in other states. Since hospitals recover their fixed costs over the length of the stay per patient, shorter stays mean higher rates per day but may not mean higher costs per procedure, and may in fact be indicative of effective cost controls. Consequently, although Washington's hospital costs appear to be out of line, that may be misleading. The lack of data analyses makes it impossible for policymakers to know how those hospital costs relate to the total cost or quality of health care. They only know that hospital costs are going up.

Chart 26 shows the growth in Hospital expenditures. The decrease between 1993 and 1996 is due to the movement of CN Kids, CN TANIF and CN Pregnant Women into managed care.

The DSHS October 15 projection for MAA estimates that Medical Assistance Reimbursements for hospital expenditures will increase 19.2 percent next biennium, growing from \$610.1 million in the 2001-03 budget period to \$727 million in the 2003-05 biennium. A review of health care expenditure trends at the national level concludes: "Hospital costs have secured their place as the



Source: DSHS

leading driver of health care cost increases, for the second straight year.”¹²

That report notes that spending on outpatient hospital services is “the fastest growing component of total spending.” As shown in Chart 27, Washington’s costs for outpatient services rose 13 percent in 2001 and a whopping 33 percent in 2002.

At a national level, hospital outpatient expenditures grew 16.3 percent in 2001 and are projected to grow at a rate of 13.6 percent for 2002¹³. The huge increase in Washington’s outpatient hospital expenditures is as yet unexplained. DSHS noted an “unexpected” \$20 million increase between the March 2002 forecast and the October 2002 forecast and has not as yet determined what drove the spending growth. Their budget assumptions appear to treat the increase as a one-time event, since they assume outpatient expenditures will return to a 12 percent growth rate in 2003. But until those costs are analyzed, the projected outpatient expenditures for next biennium should be viewed cautiously for they may be significantly understated.

Over the longer term, outpatient procedures have substituted for more expensive inpatient procedures and saved costs. Thus the fact that the outpatient growth rate exceeded the inpatient growth rate is not in itself alarming.

Inpatient hospital expenditures rose 18 percent in FY 2001 and FY 2002. DSHS predicts a drop in that growth rate to only two percent in FY 2003, going up to nine percent in both FY 2004 and FY 2005.

Hospitals are experiencing a combination of sharply rising costs, which to some extent are being passed on to private and public insurers. There have been sharp increases in wages presumably to address shortages of nurses and other skilled workers. In 2001, average hourly wages for hospitals increased 6.1 percent followed by a 5.3 percent increase in 2002. Total payroll cost increases were even greater: 8.6 percent in 2001 and 7.9 percent in 2002.¹⁴

A more significant factor in skyrocketing growth of Medical Assistance expenditures for hospital services is the rapid increase in utilization. Nationally the growth in the use of hospital services accounts for two-thirds of the total increase in hospital expenditures.

Fee-for-service enrollees may also be using more inpatient hospital services. Recognizing the high costs and growth trends in hospital inpatient services, the Washington State Legislature asked the Washington State Institute for Public Policy to perform a study of ways to avoid unnecessary hospitalizations.

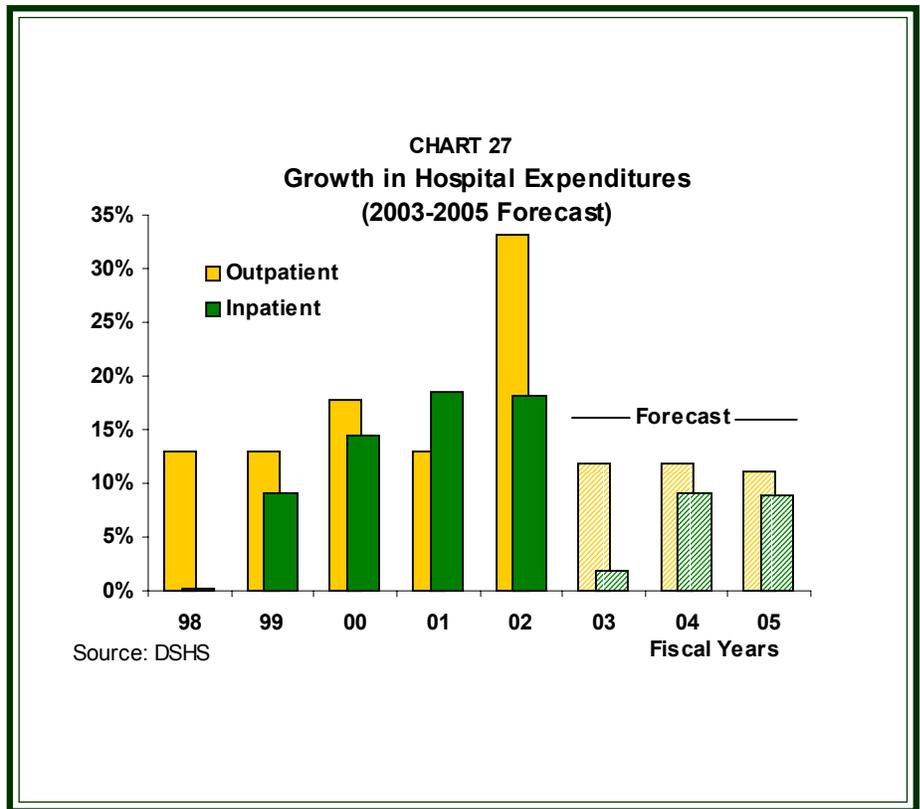
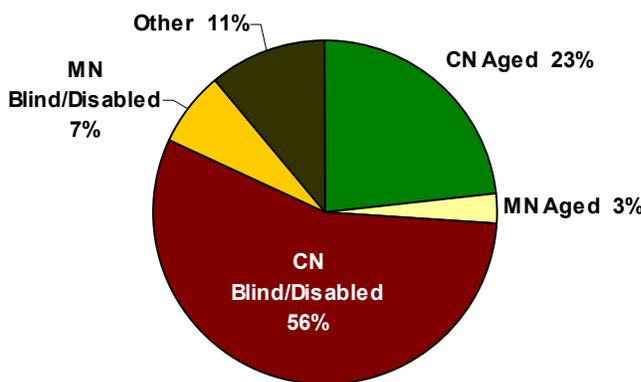


CHART 28
Number of Prescriptions Per Capita, 2001

Rank	State	Number	Rank	State	Number
1	Tennessee	16.8	26	Wisconsin	11.1
2	West Virginia	15.1	28	Georgia	11.0
3	Kentucky	15.0	29	Delaware	10.8
4	Alabama	13.8	29	Maine	10.8
5	Louisiana	13.5	31	New Jersey	10.7
7	Rhode Island	13.3	32	Vermont	10.6
8	Missouri	12.7	33	Illinois	10.5
9	Pennsylvania	12.6	34	Minnesota	10.2
10	Arkansas	12.4	35	Texas	10.1
10	Nebraska	12.4	36	Utah	10.0
12	Michigan	12.3	37	Montana	9.7
12	Mississippi	12.3	37	New Hampshire	9.7
14	North Dakota	12.2	39	Maryland	9.6
15	North Carolina	12.1	39	Virginia	9.6
16	Iowa	11.8	41	Oregon	9.1
17	Florida	11.7	42	Arizona	8.9
17	Kansas	11.7	42	Washington	8.9
17	Ohio	11.7	44	Wyoming	8.8
20	Connecticut	11.6	45	Idaho	8.7
20	Oklahoma	11.6	46	Nevada	8.6
22	Massachusetts	11.4	47	Colorado	8.5
22	South Dakota	11.4	48	New Mexico	8.4
24	Indiana	11.3	49	Hawaii	8.2
25	South Carolina	11.2	50	California	8.1
26	New York	11.1	51	Alaska	7.0
	United States	10.9			

Source: Kaiser Family Foundation, Verispan Scott Levin

CHART 29
Shares of Washington Medical Assistance Prescription Drug Expenditures, 2002



Source: OFM

The Institute's report released in August 2002, examined the potential for fee-for-service Medical Assistance clients to be hospitalized for conditions that could be prevented through regular visits to physicians and use of other outpatient care. It concluded that avoidable hospitalizations are a significant issue for Washington State reflecting 13 percent of Medical Assistance hospitalizations. A key finding of the report is, "Depending upon the cost and effectiveness of prevention services, it is possible to reduce avoidable hospitalizations and decrease state health care expenditures."¹⁵

Prescription Drugs

In 2001 there were 10.9 prescriptions written per capita in the United States. Chart 28 illustrates Washington's relatively low prescription drug use per capita. The state ranked 42nd with 8.9 prescriptions per capita.

The federal Medicare program for the elderly does not provide prescription drug coverage. In Washington and most other states Medicaid does cover prescription drugs. Analysts point out that the failure of Congress to enact prescription drug benefits for the elderly is forcing the states to shoulder that burden.

Indeed, the elderly are relatively heavy users of prescriptions and often Medicare eligible individuals also qualify for and must rely on Medicaid to pay for their prescription drugs. *Medscape* reports that low-income elderly and disabled persons made up 19 percent of the national Medicaid population, but made up 80 percent of Medicaid drug spending in 1998.¹⁶

The disabled and elderly represent an even greater share of drug expenditures in Washington.

Chart 29 shows the distribution of drug expenditures across categories for the state for FY 2002. Here, the blind and disabled accounted for 62 percent of drug expenditures, while the aged accounted for 26 percent.

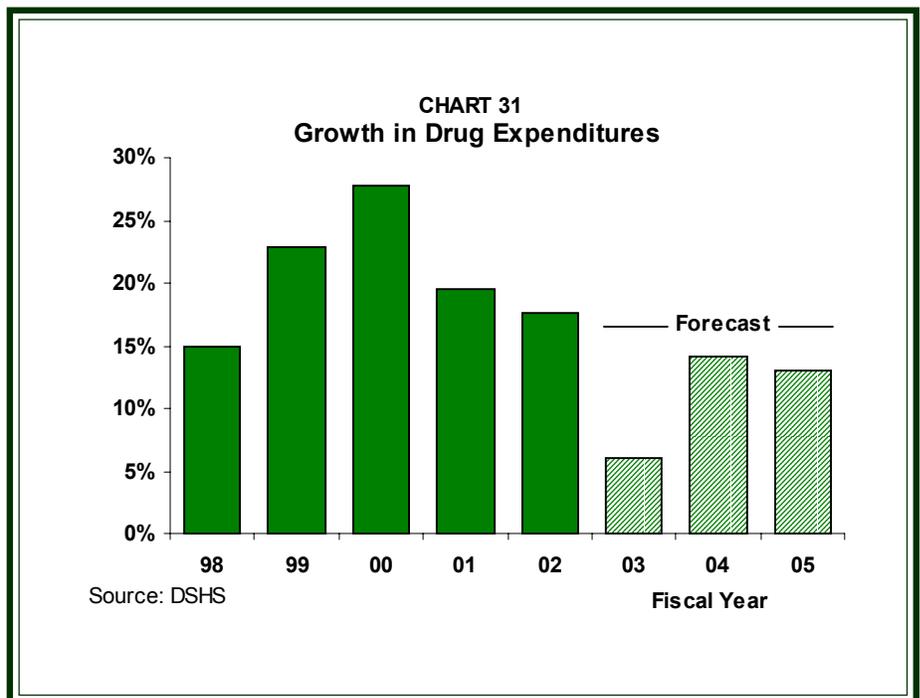
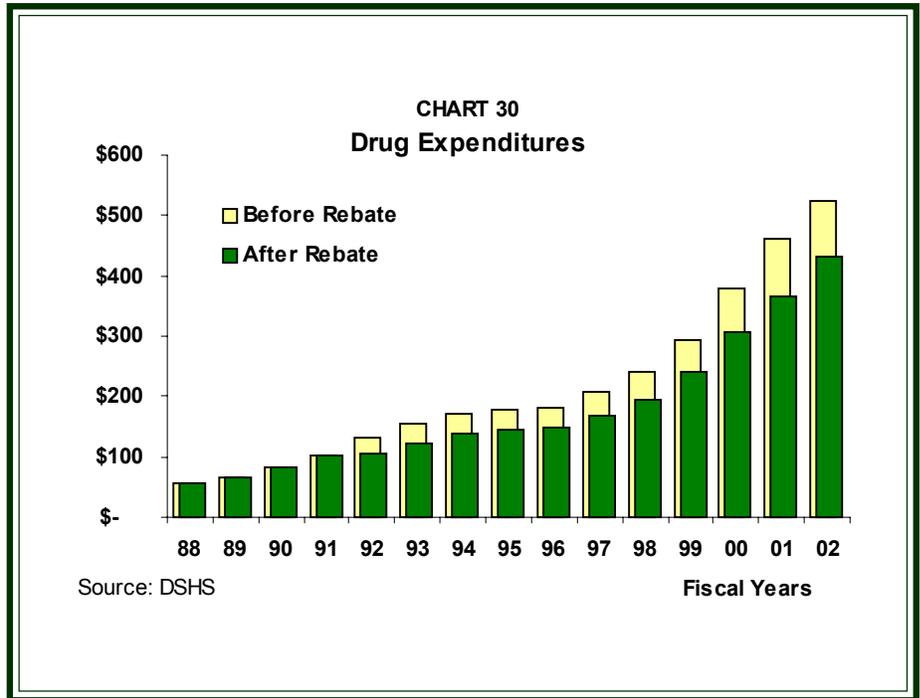
Stephen Schondelmeyer, at the University of Minnesota's PRIME Institute, reports that average drug expenditures for Medicaid recipients have been rising in almost every state's Medicaid program, but the sharpest increases have been for the blind and disabled, followed closely by the aged.

Political analysts suggest that with the Republicans now in control of both houses of Congress, there will be significant pressure to move forward with prescription drug coverage for Medicare beneficiaries.

With the CN and NM Aged categories accounting for 26 percent of Medical Assistance's spending on prescription drugs, \$138 million before rebates in FY 2002, a Medicare drug benefit could result in significant savings for the Medical Assistance program. The amount saved will depend on the details of the program finally adopted.

Drug expenditures have been a focus of cost controls since 1990, when the Omnibus Budget Reconciliation Act created the Medicaid Drug Rebate Program requiring drug manufacturers to enter into national rebate agreements in order to receive Medicaid payments for outpatient drugs. This program allows Medicaid to use its considerable market power to force rebates from manufacturers. Over the last 11 years this program has lowered Washington's cost of prescription drugs by an average of 19 percent.

Chart 30 shows the trend in prescription drug expenditures. Medical Assistance paid \$523 million for drugs in 2002, but the net cost, after rebates, was \$430 million. (Of this \$430 million, \$207 million were federal Medicaid matching funds, \$209 million came from the state General Fund, \$7 million came from the Health Services Account, and \$8 million were local funds.) The ramping up of the state's managed care program visibly slowed the growth in drug expenditures between 1993 and 1996. The three categories shifted to managed care, CN Other Kids, CN Pregnant Women, and CN



TANIF, are relatively light consumers of drugs, however. And or that reason, managed care had less effect on drug spending than it had on hospital spending.

In FY 2002, expenditures for drugs were 18 percent more than for FY 2001. DSHS projects that the growth rate will drop to 6 percent in FY 2003 and then increase to 14 percent and 13 percent for fiscal years 2004 and 2005 respectively. (See Chart 31.) The 2003-2005 projections are slightly higher than the rate of growth estimated by the Centers for Medicaid and Medicare Services (CMS).

In recent years prescription drug expenditures were the most rapidly growing service for Medicaid. The drug expenditure growth rate peaked in FY 2000. For FY 2002 the growth rate (17.6 percent) was less than the increases for inpatient, outpatient, and physician services (18.1 percent, 33.1 percent, and 27.4 percent, respectively). This mirrors the overall trend in national health care expenditures, where hospital expenditures have become the leading driver in health care expenditures.¹⁷ DSHS projects that the drug growth rate will drop to 6 percent for 2003 and again will be less than the rates for outpatient and physician services.

The low rate of growth assumed for FY 2003 is credited primarily to a change in the reimbursement rate for pharmacies directed in the final legislative budget for the 2003 fiscal year. A federal Office of the Inspector General study that said the state was paying too much to pharmacies to cover the prices they are charged by drug manufacturers recommended the cut.

Pharmacists disagreed with that study. The state cut takes the payments “down to the bone,” said pharmacist Tracey Trott of Olympia, “but also does not take into account the costs associated with serving Medicaid patients, particularly the added paperwork.”¹⁸ Several pharmacies in rural areas of the state said they could no longer afford to accept Medical Assistance prescription payments. DSHS reacted to the potential access problem for rural residents by inaugurating a mail order pharmacy for Medical Assistance clients. At this point, it is too early to measure results from these efforts.

Additional cost savings measures are part of the Utilization and Cost Containment Initiative, including the Therapeutic Consultation Service program (TCS) and the Therapeutic Academic Service (TAS) both of which began Feb 1, 2002. TCS requires a review when a Medical Assistance client receives a fifth brand-name prescription within a month. The program proposes equivalent but less expensive generic or preferred brand name drugs which must be substituted unless the prescribing physician states that the original prescription is “medically necessary.”

TAS provides increased case management using dialogues with clinical pharmacist and physicians for “intensive benefits management.” Together the programs are expected to achieve savings by reducing the cost and the utilization of drugs. Critics point out that these programs focus on Medical Assistance beneficiaries with chronic and disabling conditions who rely most on prescription drugs to maintain their health. They note the challenge is to control drug costs without jeopardizing the health of the beneficiaries and thus potentially driving up other health care expenditures.

These programs may reduce state spending on drugs, but their impact on state spending for health care is less certain. In a recent publication, *Families USA* expresses concern that state efforts to control prescription drug spending “may cause financial hardship for Medicaid beneficiaries,

create significant barriers to getting necessary prescription drugs, and ultimately lead to more costly health care.”¹⁹

Recent research by the Center for Studying Health System Change found that the percentage of Medicaid recipients reporting failure to obtain needed prescription drugs because of cost exceeded the percentages of the general population and of Medicare beneficiaries reporting such failure (26 percent vs. 12 percent and 8 percent). Forty-one percent of Medicaid recipients with two or more chronic conditions reported that they did not get at least one needed prescription drug because of cost. Moreover, the report finds that the percentage of Medicaid recipients reporting difficulty increases with the aggressiveness of the state cost control efforts.²⁰

Private insurers often try to reduce unnecessary drug expenditures by shifting a portion of costs onto patients via devices such as copayments and generic drug requirements. By making the patient share in the cost of more expensive treatment options, the insurers seek assurance that these options are chosen only when they are necessary. As the report notes, however, “policy makers should keep in mind that the impact of these methods on Medicaid beneficiaries is likely to be greater given their higher need and lower incomes, compared to most persons with private insurance.” A charge that is an inconvenience for most people with private insurance may be a major hurdle for Medicaid. The report concludes: “Despite the fact that the Medicaid program in all fifty states provides coverage for prescription drugs to most Medicaid beneficiaries, there is concern that state efforts to control the escalating costs of prescription drugs may harm beneficiary access to prescription medications, especially given the high risk characteristics of the adult Medicaid population.”

Like hospital expenditures, the growth in prescription drug spending is a result of both increased demand and higher costs. In some cases newer, more costly drugs are being substituted for older, lower-cost drugs. Although drug expenditures have swelled in recent years, NCSL notes, “it is not clear that this is undesirable.”²¹ The NCSL report points out that prescription drugs can be an alternative to more expensive care or procedures and may slow the costly progression of disease and disability. Advocates for expanding Medicare to include prescription drug coverage also argue that providing prescription drug benefits actually lowers health expenditures by reducing hospitalizations.

A recent report by the Congressional Budget Office (CBO) lends credence to those arguments. *A CBO Study of Issues in Designing a Prescription Drug Benefit for Medicare*, published in October 2002, points out that a large share of prescription drug spending pays for the treatment of chronic conditions, such as hypertension, cardiovascular disease, diabetes and other illnesses where drugs can prevent more costly hospitalizations.

CBO notes that many studies conclude that “the use of a particular drug or class of drugs would reduce, or has reduced, the use of more expensive health care services,” but that such studies tend to suffer from methodological problems and should be met with some skepticism. However CBO cites two studies by Columbia University economist Frank Lichtenberg saying they “provide suggestive evidence that increased use of prescription drugs and substitution of newer for older drugs are associated with lower use of hospitals and other health care services as well as lower mortality.”²²

In his more recent study, Lichtenberg finds that the replacement of cheaper older drugs by more expensive newer drugs saves \$7.20 in non-drug

expenditures for each \$1 it adds to drug expenditures. Of the \$7.20 in saving, \$4.40 is in inpatient hospital services.²³

DSHS Cost Containment Strategies

Utilization and Cost Containment Initiative: At the request of the Governor and the Department of Social and Health Services, the Legislature's 2001-03 biennial budget authorized about 70 additional Full Time Employees at DSHS to "aggressively pursue savings and efficiencies within the Medical Assistance Programs."²⁴ The Utilization and Cost Containment Initiative (UCCI) is multifaceted. Major elements of the initiative include:

- ❑ The Prescription Drug Cost Savings effort including the Therapeutic Consultation Service and the Therapeutic Academic Service referenced above.
- ❑ A Coordination of Benefits program that is credited with saving taxpayers \$116 million during FY 2002. The program identifies third-party payers who have responsibility for Medical Assistance clients' medical bills and then collects from them for what the state has spent and assures that they pay for ongoing medical bills of the client as appropriate. The savings to state taxpayers are not derived from reduced health care expenditures, but rather by shifting the cost of that care from the public to the private sector.
- ❑ A number of administrative review functions such as provider audits to review medical and dental care provider claims and prevent overpayments, a rates development effort to adjust Medical Assistance vendor rates when they appear to be above local or national industry norms, and a quality review program to identify non-standard utilization of Medical Assistance services, and analysis of requests for durable medical equipment and supplies to assure compliance with utilization and pricing standards
- ❑ A Family Planning Demonstration Project to help low income families avoid unintended pregnancies and
- ❑ An effort to reduce the contracted costs for transportation and interpreter services.

According to Legislative staff, the UCCI program also envisions a staff of four to six people to analyze what is actually driving the cost increases. But DSHS has been slow to fill those positions and to date there does not appear to be any such analysis available.

Value Purchasing Strategies: DSHS describes "value purchasing" as an attempt to obtain excellent quality at favorable prices. They list several value purchasing strategies including disease management programs which attempt to coordinate benefits for fee for service beneficiaries with selected

conditions like congestive heart failure, diabetes, asthma, end-stage renal disease and other cost and care intensive illnesses.

Other value purchasing strategies focus on reducing drug costs through payment reductions, generic drug pricing and use of preferred drugs. The supplemental budget assumed reduced pharmacy payment rates would save \$12.4 million for the General Fund in FY 2003. MAA was authorized to begin paying 86 percent of the manufacturer list price for single source drugs and 50 percent of list price for drugs for which there are multiple generic versions.

Although it was said such rates are comparable to those paid by other major insurers, many pharmacies, especially in rural areas, have reacted by withdrawing from or threatening to withdraw from the Medicaid program. The supplemental budget also directed DSHS to begin providing a mail-order pharmacy option for its clients no later than January 2003. It remains to be seen whether the mail order option will result in the anticipated savings.

Medicaid Reform Waiver: In August 2002, DSHS submitted a Medicaid and State Children's health Insurance Plan Waiver application to the federal Center for Medicare and Medicaid Services. If approved, the waiver would enable the Legislature to make policy and budget decisions next session and the changes would take effect in July 2003.

Perhaps the most significant element of the waiver is the requested ability to freeze enrollments in the optional Medicaid programs when expenditures appear to be exceeding budgeted amounts. The waiver would allow the state to set "trigger points" based on periodic caseload forecasts. Instead of the current treatment of the optional programs as entitlements forcing the Legislature to adopt a supplemental budget when these programs exceed the budget, DSHS would be allowed to put a freeze on accepting new enrollees, who despite eligibility for the program, would have to wait till the freeze was lifted before they could receive benefits.

The state is also seeking authority to assess \$5.00 co-payments for prescription drugs when there is a lower cost generic or therapeutically equivalent drug available. And, in attempt to control costs from unnecessary and expensive emergency room care, DSHS would impose \$10 co-pays on non-emergent visits to an emergency room. The department has proposed establishing a 24-hour Medicaid consulting nurse hot line to help sort out non-emergency cases and prevent access problems.

Additionally, for certain optional adult and children's programs the waiver would allow the state to require a small premium to be paid by Medicaid beneficiaries with income above the Federal Poverty Level (The FPL currently is \$8,590 for an individual or \$17,650 for a family of four).

Other key parts of the proposed Medicaid Reform waiver:

- ❑ An ability to change the benefit package for adults in certain optional programs, making those programs more similar to the Basic Health Plan by eliminating vision, hearing and non-emergency dental coverage.
- ❑ Let the state use its unspent SCHIP allotment funds to expand coverage to parents of Medicaid and SCHIP children and possibly childless adults, through expanding

the Basic Health program. Currently, the state must return those funds at the end of each year.

- ❑ The waiver would not apply to long-term care services, such as nursing homes, or to home- and community-based care.

DSHS advocates the waiver as way to get the flexibility they need to continue Medicaid coverage for the most vulnerable while avoiding the current consequences of budget overruns. Under the entitlement programs today the state's only options are to reduce payments to providers, eliminate entire programs, eliminate services or find other revenue sources such as increased taxes to cover Medicaid costs.

In response to a CMS request, Washington submitted the waiver as Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA). The purpose of the HIFA demonstration is to encourage states to expand coverage to new populations. CMS does not offer states any new federal funds with which to help finance such expansions. Instead, states must finance any expansions that they adopt with "savings" that they generate by reducing spending on current beneficiaries or by drawing on unexpended SCHIP monies.

Although DSHS expects to receive approval on the waiver, that is not a foregone conclusion. Many advocate groups are lobbying CMS to deny the waiver request. They fear that the state's implementation of costs controls will lead people to forego critically necessary services. The Washington Area Agencies on Aging says, "The introduction of Medicaid premiums, complex co-payments and even more complex enrollment freezes would increase bureaucracy and undermine the health and well-being of people least able to fend for themselves. The anticipated savings are likely illusory. It is well documented that the needs of chronically ill and disabled people are better met if timely and coordinated rather than being denied and postponed. The result may be increased ER, hospital, nursing home and prescription drug bills".

Findings

Washington State faces an increasingly difficult fiscal situation. The budget shortfall may exceed \$2.5 billion. Medical Assistance is one of the most significant cost drivers in the state budget and Medical Assistance Administration programs funded by Medicaid are experiencing increased enrollments and higher costs. Most, if not all, MAA spending categories are growing faster than the general rate of inflation. Therefore, policymakers will be forced to look to cuts in MAA as they attempt to balance the budget without major revenue increases.

Medicaid provides vital life-giving services to the most vulnerable populations. Managing its budget without doing harm is one of the most significant challenges lawmakers will face. The multifaceted growth in MAA spending has many complex causes: the initiation of new programs, increased enrollment in existing programs, increased utilization of existing services, the invention of new procedures, devices, and drugs, and simple inflation.

Cost control options have equally complex interactions and consequences in health service areas for the needy. MAA funds a multitude of health service programs that are interrelated. High expenditures in one area, such as prescription drugs or managed care may lower expenditures in other areas, such as hospitalizations. Reduced expenditures in some programs, if they're a result of deferred or denied service, can result in higher future treatment costs.

If CMS approves DSHS's Medicaid Waiver application, the Legislature will have the flexibility and the responsibility to determine how to manage MAA programs to achieve more cost-effective care. But, for the most part, data is not available or analyzed in a manner to help determine the cost effectiveness of services.

Every dollar spent in Medicaid programs in Washington State is matched by another dollar from the federal government. Thus, every dollar cut from the state budget, is two dollars cut from the health service programs serving the poor.

Recommendations

Governor Locke's Priorities of Government process provides a framework for making budget decisions. Under this process budget writers are urged "to identify results that . . . people want from state government, provide strategies for achieving those results and allocate spending within existing resources."²⁵ This represents a fundamental reorientation in the way the budget is prepared. Applied to the medical assistance program, that means determining what outcomes the state's citizens expect from the program and the most cost effective means of achieving these outcomes.

The area of medical care is experiencing rapid changes in technology. An incremental approach that simply clamps down on the areas of expenditure that are rising most rapidly begs the most important question: what service provided to which client provides the most bang for the taxpayer's buck. Rapid increases in expenditure often occur precisely in those areas where rapidly changing technology is providing new cost-effective means of improving health. For example, pharmaceuticals are one area where the introduction of new treatment options has lead to increased expenditures. But evidence indicates that increased use of new drugs reduces costs overall. Moreover, new drugs save lives and increase quality-of-life. They may well represent the very best use of scarce health care dollars.

The state lacks a comprehensive management information system to provide the information it needs to evaluate the cost effectiveness of the current Medical Assistance program and assess the potential costs and benefits of proposed budget and policy changes. Such a system should be developed.

In the near term, without such information, policymakers must avoid the temptation to focus on discrete service area cost trends, and instead consider the cost-effectiveness of the state's MAA programs as a whole when they develop budget strategies for health care services.

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