State Health Watch

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In This Issue

Cut Medicaid or change it? Drawing lines between cost and coverage

Two respected health researchers say the Bush administration's plans to cut $26 billion from Medicaid spending over the next five years are misguided, and what is needed is a fundamental restructuring of the program to cover more people and shift more costs to the federal government. In a *Health Affairs* analysis published Feb. 25, 2007, Urban Institute Health Policy Center director **John Holahan** and National Academy for State Health Policy executive director **Alan Weil** say the four reform options they suggest "would go a long way toward solidifying the system of financing care for low-income Americans. They would simplify Medicaid's structure, expand coverage for low-income populations, and largely eliminate the financial manipulations that have plagued the program in recent years. They would shift more financial responsibilities to the federal government, which has far superior taxing and borrowing capabilities, and thus provide fiscal relief to states."

If it all sounds too good to be true, Mr. Holahan and Mr. Weil acknowledge that one major problem is that it will be hard to sell such ideas politically. "We recognize," they say, "that the nation faces a

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States improving Medicaid dental care Community and provider support key to success

Some states are experimenting with new ways of delivering dental care to Medicaid patients and reporting good results.

In Rhode Island, an oral health access project funded by the Robert Wood Johnson Foundation through the Center for Health Care Strategies led to design and implementation of the RIte Smiles program. The program goal was to improve access to dental care for children enrolled in Rhode Island Medicaid.

Fiscal Fitness: How States Cope

The Oral Health Access Project partnered with Rhode Island Foundation and Rhode Island KIDS Count and awarded performance-based grants for 15 different projects that were key building blocks to increase access to dental care for the state's most vulnerable populations.

Rhode Island Department of Human Services oral health project manager **Martha Dellapenna** tells *State Health Watch* the grants developed access to school-based oral health services in core communities,

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Reform

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large structural deficit well into the future and that an expansion of a major entitlement program is not likely to be politically feasible in the near term. But any effort to expand health insurance coverage faces the same obstacle. The question is whether the federal straitjacket that has been the outcome of recent federal tax and spending policies should foreclose debate over tackling such major national problems." They say while they are under no illusion that their proposals are politically feasible, they believe that those pursuing true reform must address the issues they are raising.

Mr. Weil tells *State Health Watch* that it will take a serious discussion of comprehensive reform or universal coverage to get the ideas he and Mr. Holahan are advancing on the table. "Once the discussion broadens in that regard," he says, "it will be natural to include the role of Medicaid in the overall conversation regarding how we will cover everyone. This will open the door to conversations regarding what the publicly provided base of coverage should be [Medicaid] and the relative roles of the states and the federal government. Barring a true fiscal crisis at the state or federal level, it will be difficult to discuss reforms of the magnitude we propose."

Mr. Holahan tells *SHW* he agrees with Mr. Weil and says interest in broad reform with a significant role for states would make it imperative to look at the issues they raise. "Growing fiscal pressures on states because of rising health care costs coupled with slow revenue growth could also do it, particularly with a recession. Unfortunately, our piece was published in a year in which Medicaid costs are growing quite slowly, so this is off the radar screens at the moment. But this won't last."

Cost containment or cost-sharing

"In our opinion," Mr. Holahan and Mr. Weil say, "many of the ideas emerging from the reform proposals currently on the table are appropriate, such as increased emphasis on wellness and prevention; improving care coordination for higher-need populations, including dual-eligibles; and investing in information technology. But we also believe that there is much in the Deficit Reduction Act and recently approved waivers that represents the wrong approach to Medicaid cost containment and is not true reform."

The two say that while their proposals would certainly increase federal spending, their cost-containment policies should lower the rate of growth below current projections. "But the higher spending estimates should also be put in perspective," they wrote. "In the four models we described, federal spending would increase, but state spending would decline. The net effect of $26-$30 billion annually is clearly an overstatement because the reductions in the number of uninsured people would reduce the federal, state, and local costs of supporting the safety net, and increased Medicaid enrollment would reduce some costs for employers and individuals as well." And a companion *Health Affairs* study indicates that Medicaid may not be facing an immediate financial crisis requiring major cuts ***(see related story, p. 7)***.

The policy researchers say many Medicaid reforms being discussed and implemented rely on a series of mistaken assumptions and beliefs about why Medicaid costs so much. Specifically, they say, a major impetus for Medicaid reform has been a

concern that enrollees over-use services. That concern, they say, is reflected in a variety of views expressed by some reform proponents. Thus, some of the alleged overuse is attributed to the idea that when people are shielded from the actual price of goods or services they use, they will consume more than is appropriate. Others speak of the "Cadillac" Medicaid benefits package that includes services generally not part of commercial insurance and in many states lacks numeric service limits on benefits such as physical therapy.

Such concerns, according to Mr. Holahan and Mr. Weil, naturally lead to policy responses such as increased cost-sharing for enrollees, particularly at the point of service; reducing the benefits package to exclude certain services, at least for some populations; or capping services such as setting a limit on the number of prescriptions to be filled each month.

For some reform advocates, they say, the appropriate response is even more fundamental change, such as extending use of high deductible insurance policies paired with health savings accounts for the very low-income Medicaid population, with a primary goal of making enrollees more conservative purchasers.

"The notion that a central principle of Medicaid reform should be giving enrollees financial incentives to reduce use ignores the long-standing reality that enrollees have difficulty finding health care providers who will accept Medicaid," the authors caution. "Research consistently shows that Medicaid enrollees have access and utilization levels comparable to those of the privately insured when differences in the populations are controlled for. In addition, these proposed policies are usually suggested for low-income parents and children, not for elders and people with disabilities. But parents and children on Medicaid are already mostly enrolled in managed care plans, which have systems designed to reduce unnecessary use. These enrollees only account for 31% of Medicaid spending, which means that even if the policies have their intended effect, they will have a limited effect on overall Medicaid costs."

Mr. Holahan and Mr. Weil warn that while efforts to reduce benefits and increase cost-sharing may in fact save money in the short-term, they may have implications well beyond cost, including lower use, which could lead to increases in unmet needs and negative health consequences, particularly for people with chronic conditions. Also, reform proposals based on shifting costs to enrollees are not likely to do much to control program spending. They contend the real reason for recent growth in Medicaid spending has been enrollment growth among families and children because of the economic recession and growing income inequality, growth in the number of disabled enrollees because of the increasing incidence and recognition of disability, and medical care inflation in the health sector.

Four reasons for reform

Even though they don't see the value in many of the current Medicaid reform proposals, Mr. Holahan and Mr. Weil say there are at least four reasons Medicaid does need to be reformed.

First, they say, Medicaid program costs and cost growth are a growing burden for states and given this fact, states will regularly be forced to make marginal cutbacks in coverage and benefits that will harm beneficiaries, undermine program goals, and increase the number of uninsured Americans. "States probably cannot continue to support Medicaid as well as other priorities such as infrastructure and education," they say. "Some fiscal relief needs to be part of any serious Medicaid reform effort. A reformed Medicaid program should recognize the broader taxing and borrowing authority of the federal government and the greater volatility of state revenues, and place more of the cost and risk for cost growth onto the federal government."

The second driver they see for reform is that interstate variations in Medicaid, particularly involving coverage and provider payment rates, are too great given the dominant funding role of the federal government and the national interest in providing for the health care needs of low-income families, elders, and people with disabilities. Thus, a reformed Medicaid program should reduce interstate variation in eligibility and provider payment.

Third, complex, restrictive federal eligibility standards contribute to the large number of people who are eligible but not enrolled and divide families in ways that make it difficult to build on the base of Medicaid coverage with tax credits, subsidized coverage, integration with employer-sponsored insurance, or any mechanism designed to reduce the number of uninsured Americans.

And finally, the current program design has features that promote mistrust between states and the federal government regarding whether Medicaid funds are being used to achieve the program's purpose. Specifically, Mr. Holahan and Mr. Weil say, the use of disproportionate share hospital payments, upper payment limits, and similar mechanisms in which state financial participation has been questionable has soured federal-state

relations. In a reformed program, they say, financing arrangements that states have used to leverage higher federal matching payments with little or no state contribution should be eliminated.

Key reform needs

Key features of their reform options include, first, expanding coverage up to a national minimum eligibility standard, increasing the uniformity of Medicaid coverage among states and reducing the number of uninsured low-income Americans, particularly in states with more limited Medicaid coverage. Second, shifting populations or services to the federal government would provide states with fiscal relief and increase the federal government's incentives to invest in care management for these populations. Shifting other populations or services to states would make states wholly responsible for these services, potentially improving system efficiency and offsetting federal costs from the shift of other services to the federal government. Next, increasing federal matching rates would provide fiscal relief and increase incentives for states to add coverage and provide adequate benefits and to avoid punitive reductions in coverage and benefits. Finally, reform of disproportionate share payments, upper payment limit programs, and other similar programs in which states make little or no real contribution but can leverage federal dollars would curtail inappropriate use of federal outlays.

More than one way to reform

Mr Holahan and Mr. Weil say each of their four reform options would have approximately the same budget impact on the federal government and savings to states. The options differ in their relative emphasis on coverage expansion, acute or long-term care, and federal and state responsibilities. They say their idea was to show that there are different ways to achieve major reform and say those wanting to implement reform could pick and choose policy changes within the four options.

The options they advance are:

1. Terminate SCHIP and integrate all children's coverage into Medicaid with no enrollment caps. Premiums such as in the current SCHIP program would be allowed. Coverage of adults would be expanded to 150% of poverty, with a 30% enhanced match. States could expand further for children and adults at the enhanced matching rates. Federal matching rates on all acute care services for current beneficiaries would be increased by 30%, with no change in matching rates for long-term care. The federal government would be responsible for Medicare premiums and cost-sharing for Medicare acute care services. The current "clawback" policy for prescription drugs would remain in place. Disproportionate share payments would be eliminated.

2. This option, similar to the first, equalizes matching rate increases across services and programs. Federal matching rates for all services including long-term care would increase by 15%. SCHIP would be retained in its current form but with the matching rate reduced to 15% above current Medicaid rates. Coverage of adults would be expanded to 150% of poverty with a 15% enhanced match. States could expand further for both adults and children at the 15% enhanced match. Acute care services for dual-eligibles, including state clawback payments, would become the responsibility of the federal government, and disproportionate share payments would be eliminated.

3. This option would expand coverage for adults only to 100% of poverty, allowing states to go further if they choose. The current Medicaid/SCHIP structure for children would be retained. The federal government would be responsible for acute care services for dual-eligibles, including eliminating the drug clawback. Because the mandatory coverage expansion would be less, disproportionate share payments would not be eliminated but would be restructured with a new formula based on the number of low-income people and potentially the number of recent immigrants.

4. The last option, considered by Mr. Holahan and Mr. Weil to be the most dramatic, would federalize all care for dual-eligibles, including long-term care, but not including Medicare acute care services. The prescription drug clawback payment would be eliminated. Long-term care services for nondual-eligibles would be wholly a state responsibility. The current Medicaid/SCHIP structure for children would be retained. Coverage of parents and nonparents would be expanded to 100% of poverty and states could expand further with current federal matching payments. The current matching payments on all Medicaid services would be retained and states could expand at the current matching rates. Disproportionate share would be restructured but not eliminated.

The authors say Medicaid reform is an important priority and the cost pressures the program places on state governments often affect their ability to adequately address other priorities. Funding pressures also cause states to reduce Medicaid benefits and provider payment rates. At the same time, states' reluctance to expand coverage to levels that are allowed by federal law contributes to

the high number of and growth in uninsured Americans.

Shifting costs

At a Feb. 23, 2007, Washington briefing at which their paper was released, Mr. Weil acknowledged there are inefficiencies in the current Medicaid program, but said a general strategy of shifting costs to the enrollee population or scaling back benefits is unlikely to yield savings. "I think," he said, "as we've seen a new body of evidence in just the last few years with recent changes in health care delivery, the risks to populations with chronic conditions in that kind of increased cost-sharing is substantial with respect to their health status. So needless to say, we conclude that starting a Medicaid reform discussion with the idea that what you're going to do is take away from some to save money and have no health consequences is not an appropriate starting point."

Mr. Holahan said increased federal spending would range from $41 billion to nearly $49 billion depending on the option. Much of that money would go to coverage expansion, but also would be needed to cover the cost of the federal government taking on new functions and higher matching rates.

All states would save money under all four options, due primarily to shifting responsibility for dual-eligibles to the federal government and higher income from higher matching rates. Some of that would be offset by higher state costs for coverage expansions.

While the net cost of $26 billion to $30 billion is clearly a lot of money, Mr. Holahan said, any proposal to expand coverage to low-income people in any significant way will face the same level of costs. "I think if you're going to have a serious discussion about this, you should get used to numbers like that," he said.

The bigger context

Also at the briefing, George Washington University associate professor **Jeanne Lambrew** said the study by Mr. Holahan and Mr. Weil "tries to get us out of the minutiae of looking at different parts of the Medicaid statute and putting this into a bigger context. Who should be covered? Who should pay? How do we think about this in a disciplined way? That's a real addition to our current debate when we typically are focused on kind of the narrow policy issues of the day."

Ms. Lambrew said the report also challenges the conventional wisdom that the country is spending too much on Medicaid at the federal budget level. In that term, she said, spending too much at the federal level implies that we basically have some sort of cost problem. But, she said, what we really have is a coverage problem.

"We have enrollment increases that are driving our costs," she explained. "And if we actually believe coverage is good, I'm not sure how we say that a cost increase associated with increased enrollment is a problem. I think what we see in the Holahan and Weil paper implicitly, and I think it's something we should discuss, is they're saying we actually think the federal government should be paying more, not less, because of its broader tax base and because we can rationalize some of our spending. I think that's an interesting contribution to this debate that does stretch the bounds."

Access the paper at http://content.healthaffairs.org/cgi/content/abstract/26/2/w254. Contact Mr. Weil at aweil@nashp.org and Mr. Holahan at jholahan@ui.urban.org. ■

Fiscal Fitness

(Continued from cover)

enhanced safety net dental clinic capacity in underserved areas, and addressed work force issues. Under the program, she says, a pediatric dental residency program was expanded, a general residency program was launched, 11 residents were added at two Providence inner-city hospitals, and a 10-week dental assistant training program was established for parents on welfare who are returning to work.

Needing to remain budget-neutral, Rhode Island obtained a Section 1915(b) Medicaid waiver from the Centers for Medicare & Medicaid Services and used an experienced Medicaid dental managed care organization for value-based purchasing that focused on prevention and primary care to avoid costly dental procedures long term.

RIte Smiles has the same dental benefits as Medicaid fee-for-service, Ms. Dellapenna says. There are no copays or premiums for families to pay, and enrollment in the plan is mandatory for eligible children born on or after May 1, 2000. The plan contracted with United Healthcare Dental, which offered a statewide network of participating dentists and dental specialists to choose from, as well as claims processing, customer service, and provider relations services, and coordination of transportation and interpreter services as needed.

Short- and long-term savings

Short-term savings in the Rhode Island program were achieved by changing the state's Medicaid orthodontia criteria. Ms. Dellapenna says long-term savings will be achieved by getting children into the dentist for early and regular care and education

and prevention to decrease incidence of dental caries and more serious dental conditions.

By the end of last year, the state had expected to enroll some 30,000 children in the program. The number of actively participating dental providers went from 27 to about 160 and continues to increase. And reimbursement rates were increased to be more in line with the prevailing commercial PPO rates in the state.

Keys to success

Ms. Dellapenna says the keys to the program's success include taking a client-based approach, implementing RIte Smiles without additional money in a time of fiscal austerity, very strong community collaborations and partnerships, support from the dental provider community, and dental society and legislative support. Often, she tells *SHW*, dentists were not accepting Medicaid patients because of inadequate reimbursement rates. "We told the vendor we needed better doctor participation," she says. "The rates are now close to the prevailing commercial rates and the doctors tell us the new rates are fair, despite being discounted." Ms. Dellapenna also says United has done a good job in working with dentists on the best ways to treat very young children as patients and on cultural issues.

She says the vendor managed to create a lot of excitement among providers to be part of the new program. As a result, providers were expecting increased volume of patients and that was slow to develop because it took time to educate parents on the idea of bringing their children to the dentist.

Apple Tree meets special needs

In Minnesota, Apple Tree Dental, a private, nonprofit dental organization that has been operating for more than 20 years has been working to improve the lives of people with special dental access needs. Apple Tree provides dental health services, community leadership, and education, all flowing from a vision that says: "We believe that oral health is a basic human right and needless suffering must be eliminated. We envision a future where everyone from the very young to the very old are able to obtain the care they need."

Solving access problems

Apple Tree's Twin Cities director of dental services **Jayne Cernohous** tells *State Health Watch* the program combines government-funded programs with private programs and nonprofit grants to provide preventive, restorative, surgical, and prosthetic services through a central clinic and a mobile program involving six mobile offices, 15 Head Start centers, 75 long-term care facilities, two schools, and eight group homes. She says many patients are seen where they live through the mobile clinics. Facilities that realize they have a need contact Apple Tree, she says, and Apple Tree arranges to provide mobile services if it appears it will work.

Ms. Cernohous says Minnesota's dental access problem can be seen in statistics showing that 30% of 600,000 enrollees in public health programs see a dentist in a 12-month period and only one-third of the state's dentists provide more than $10,000 in services to public program patients, with one-quarter of the dentists seeing no public program patients at all. One reason is that public programs pay less than 50% of the average billed charges. The majority of patient complaints about access to the state ombudsman's office involve dental access, even though dental care is less than 2% of the health care budget.

In response to a state request for proposal, Apple Tree was awarded a planning grant for what is known as the Oral Healthcare Solutions Project. The project's goal was to design a new oral health care system to deliver improved oral health care and contain the cost per person treated. Apple Tree and the state have been working to obtain needed federal waivers for a model that Apple Tree would likely run.

Money spent questionably

Ms. Cernohous says the old Medicaid model spends more than half on diagnosis and prevention and less than half on all other dental care. The Medicaid model also promotes costly and questionable utilization patterns, she says, such as twice-yearly checkups and pumice prophylaxis for children, as well as systematically neglecting vulnerable adults and elders and failing to provide adequate access for low-income children.

The new system, she says, aims to reduce costs by: 1) providing less costly education, prevention, and screening services; 2) optimizing new roles for all providers; 3) optimizing frequency of diagnosis and effectiveness of treatment; and 4) reducing indirect costs.

Meeting patients', dentists' needs

The program provides patients a single point of contact and a virtual dental home through a help center. There are multiple points of entry and treatment. Existing dentist-patient relationships are unaffected, and existing health plan medical coverage is unaffected.

For dentists, Ms. Cernohous says, the program addresses their five leading complaints by providing higher reimbursements, from 65% to 85% of the usual, customary, and reasonable payment; assistance from the help center to prevent no-shows, no denial of payment with "respectful referrals;" no

managed care commercial links, published reimbursements, minimal administrative barriers, and a trusted source of prompt payments; and multi-step procedures paid with "respectful referrals." Other concerns the program addresses include the freedom to control participation level, the freedom to offer alternative treatment options, and the freedom to participate as "specialists."

Ms. Cernohous tells *State Health Watch* that Apple Tree's success in the last 20 years relates to having a good idea of what services populations need, researching before opening a facility, and working with advocacy groups. "We're here for patients who have no place else to go," she says. "We don't want to displace people who are being served well.

Information on RIte Smiles is available online at www.dhs.ri.gov. Contact Ms. Dellapenna at *(401) 462-5300. Information on Apple Tree is available online at www.appletreedental.org. Contact Ms. Cernohous at (651) 238-6529.* ■

Notion of Medicaid cost crisis disputed

A new study of Medicaid future funding requirements by the Kaiser Commission on Medicaid and the Uninsured projects a less dire situation than often suggested by conventional wisdom. Published in the Feb. 21, 2007, web-exclusive edition of *Health Affairs*, the study by **Richard Kronick**, of the University of California, San Diego, and **David Rousseau** of the Kaiser Commission on Medicaid and the Uninsured, concluded that expected growth in government revenues is likely to be large enough to sustain Medicaid spending increases over the next 40 years while allowing substantial real growth in spending for other government services.

The authors say there has been no careful look at long-term Medicaid spending and the availability of government revenues to support it comparable to the annual examination of Medicare's financial status in the Medicare trustees' report. Mr. Kronick and Mr. Rousseau say their analysis fills that gap by providing a detailed forecast, based on historical trends, of projected spending over the next 40 years, 2005-2045, for Medicaid as currently structured and comparing projected Medicaid spending to projected overall health spending and federal and state revenue growth.

"Even under pessimistic assumptions, the study provides a new perspective on Medicaid's future financing," Mr. Kronick says. "While a substantial component of state government spending, Medicaid is not likely to be the financial burden squeezing out other public priorities that some policy-makers fear."

After accounting for demographic and health coverage trends such as an aging population and declines in employer-sponsored insurance, the study found that Medicaid's share of national health expenditures is expected to remain at an average 16.6% from 2005 to 2025 and slowly rise to 19% by 2045. However, as overall health spending increases as a share of gross domestic product from 2005 to 2045, there will be a commensurate increase in the share of gross domestic product (GDP) represented by Medicaid spending, according to the study. Thus, the authors said, "there is little that is special about Medicaid spending: It is likely to increase with health spending more generally, neither much more quickly nor much more slowly."

Surprising findings

In an interview recorded for the Kaiser Family Foundation, Mr. Kronick says he was surprised to run the numbers and not find that Medicaid spending would continue to increase as a share of health spending as it has over the last 10 years. "The projection of relatively flat spending as a share of national health spending was somewhat of a surprise," he said.

Kaiser Commission on Medicaid and the Uninsured executive director **Diane Rowland** said Medicaid, which covers 55 million people as an integral part of the nation's health care system, "experiences the strains and pressures of the overall health system. This first-of-its-kind study of Medicaid makes it clear that the growth over the next 40 years in Medicaid spending will largely be driven by the growth of health spending as a share of the economy. If there is a culprit in the room, it is not Medicaid but ever-rising health costs that threaten future sustainability. Efforts to reduce the growth in Medicaid without shifting costs or threatening coverage will ultimately require better controlling the rate of growth of health spending overall."

The study projects that as overall health spending grows in the next 40 years, Medicaid also will grow, but will stay at roughly the same share of national health spending in the coming decades

due to three factors:

1. Although many adults are expected to lose employer coverage, few of them are eligible for Medicaid under current rules, and although more children are expected to enroll in Medicaid, the program's low per-capita spending for children limits the impact of that higher enrollment.

2. The increase in the number of Medicaid disabled enrollees drove growth in the program's spending historically, but growth in this population has slowed in the past decade and is projected to remain slow over the next 25 years.

3.The projections assume that nursing home and home health prices will grow roughly at the rate of growth of wages (which grow far slower than health care spending), meaning that while elderly people will need long-term care, Medicaid long-term care spending as a share of overall health spending is not likely to increase significantly.

Revenue growth analysis

Mr. Kronick and Mr. Rousseau say that if Medicaid spending and state and federal revenue growth continue to follow long-term historical trends, then state revenues available for non-Medicaid public priorities are projected to grow at an inflation-adjusted 2.5% per year through 2025, roughly the projected rate of inflation-adjusted (GDP) growth. And even in a scenario in which state revenues do not increase as a share of GDP and state Medicaid spending grows more quickly, state revenues for non-Medicaid services still would increase through 2025. Spending pressures will be somewhat greater in the two decades following 2026, but under all but the most pessimistic scenarios, states still can expect substantial revenue growth for services other than Medicaid.

"While some states in some years will no doubt experience significant fiscal strain due to Medicaid spending growth, particularly during periods of recession, the long-range scenario for Medicaid's impact on state revenues is not calamitous," Mr. Rousseau said. And the study shows a similar picture for federal revenues, with growth in revenues for non-Medicaid services averaging an inflation-adjusted 2.3% annually from 2006 to 2025, slightly lower than the inflation-adjusted 2.5% if Medicaid spending had remained constant as a share of GDP for the period.

Mr. Kronick and Mr. Rousseau report that state revenues raised from sources within the state, excluding intergovernmental transfers, increased steadily from 6.4% of GDP in 1977 to 7.4% in 2000. The recession and dot.com bust of 2000 resulted in a sharp break from the 1997-2000 trend line, they say, reducing state revenues to 7% of GDP in 2003. State tax revenues rebounded in 2004 and 2005 and reached some 7.3% of GDP in 2005.

The authors say their analysis of the pattern of state revenue growth from 1997 to 2005 leads them to expect that state revenues will continue to grow modestly as a share of GDP from 2005 to 2045. If they continue their historical pattern of growth, they say, they will grow from 7.3% of GDP in 2005 to 8.9% in 2045, an average real growth rate of 2.8% per year from 2006 to 2025 and 2.5% from 2026 to 2045. If, alternatively, state revenues stay constant at 7.3% of GDP from 2006 to 2045, then real state revenues will grow at the rate of real GDP growth, estimated to be 2.3% per year from 2006 to 2025 and 2.0% from 2026 to 2045.

"Even assuming that Medicaid spending grows as a share of GDP, real state revenues for services other than Medicaid are projected to grow as well, although the level of growth depends on the level of state revenue growth, the level of Medicaid spending growth, and the time period under consideration," Mr. Kronick and Mr. Rousseau say. "If, as seems most likely, state revenues continue to grow modestly and Medicaid spending follows our intermediate projections, real growth in state revenues for services other than Medicaid will average 2.5% per year for the next 20 years. This is lower than the real growth rate of 2.8% per year that states would enjoy if Medicaid spending remained constant as a share of GDP, but still is well above zero and is slightly higher than the projected rate of GDP growth.

"If state revenues remain constant as a share of GDP, or if Medicaid spending grows more quickly than in our intermediate projections, state revenues for services other than Medicaid will grow more slowly, but in all scenarios, states are expected to enjoy real revenue growth for services other than Medicaid for the next two decades."

The authors conclude that despite fears about declines in employer-sponsored insurance, increases in the number of disabled people, and the long-term care needs of baby boomers, it appears that there is little that is special about Medicaid spending: It is likely to increase with health spending more generally, neither much more quickly nor much more slowly. "Short of pushing beneficiaries into the ranks of the uninsured or greatly reducing Medicaid benefits, there is little that can be done to greatly reduce Medicaid spending growth in the medium term except to do something about reducing overall health spending growth," they say. "Medicaid is one purchaser in a

larger health care market, and with payment rates already much lower than those of other payers and with an overall populations far more costly than that covered by private insurance, the most effective way to control Medicaid spending growth is to pursue strategies to control overall health care cost growth….We hope that this work makes clear that there is no need to rush headlong into changes in Medicaid for fear that Medicaid is unsustainable or will bankrupt state and federal taxpayers. A measured and careful approach makes much more sense."

Mr. Kronick said there are two main policy implications to his study. First, it needs to be recognized that Medicaid is not the Pac-Man that ate state budgets, as it is sometimes described, and that governors and state legislatures and federal policy makers have the luxury of taking a measured and reasoned approach to Medicaid program changes. "We don't need to rush headlong and make major changes in Medicaid because of the fear that it is going to bankrupt the public sector. That would be the first major policy implication. And then the second is that, to the extent that we are and should be concerned about the future of Medicaid and the fiscal pressures that it will create, the main area we should be focusing on is the overall rate of growth of health care. We need to do something about slowing the rate of growth of health spending more generally, which will also then have an effect on the Medicaid rate of growth. But there's relatively little that could be done other than throwing people off the program or slashing benefits that would significantly reduce the rate of Medicaid spending growth over the next 40 years, other than changing the rate of growth of overall health care spending."

Authors' conclusions questioned

Responding to the analysis, National Association of State Budget Officers (NASBO) executive director **Scott Pattison** tells *State Health Watch* his organization has questions about the assumptions the authors used to reach their conclusions. "We do not often hear the claim that governments can sustain Medicaid increases plus infrastructure, universities, corrections, transportation, and the list goes on and on," he says. "It is not clear what assumptions the authors are making about all of these other services. Does it include capital investment for transportation and/or funding liabilities in pensions and other employment costs?"

Mr. Pattison says that while the authors suggest that Medicaid as a percentage of health expenditures and GDP will not change substantially over the 40-year study period, NASBO would want to know how that relates to the reality that Medicaid has become an increasingly larger share of state spending over the last 20 years and why they think that trend will not continue.

He notes that when the Urban Institute's **John Holahan** presented his Medicaid reform ideas ***(see related story)***, he referred to Medicaid costs as "a growing burden to states," and asks whether that notion fits the report's conclusion.

"During the last economic downturn, states were aggressive in cost containment in Medicaid and would have had to make further reductions without the federal fiscal relief package," Mr. Pattison recalled. "In addition, states made many cuts or had no increases to a variety of other programs. During the 40-year projection period, we would want to know what are the assumptions about downturns in the economy. During another downturn, we would expect this same scenario, where many spending cuts are made even with state rainy day funds, etc."

CMS: Spending takes 20% GDP

Meanwhile, Centers for Medicare & Medicaid Services (CMS) analysts say that over the next decade America's spending on health care is expected to double from today's level, reaching $4.1 trillion and consuming almost 20 cents of every dollar spent. Spending in 2006 is projected at $2.1 trillion or 16% of GDP.

The analysis published in the Feb. 21, 2007, web-exclusive edition of *Health Affairs* says the average annual growth in health care spending is projected to remain relatively steady at 6.9% from 2006 through 2016. The growth in health spending is expected to drop slightly from 6.9% in 2005 to 6.8% in 2006, marking the fourth consecutive year of a slowdown in spending, according to preliminary data.

CMS National Health Statistics Group deputy director **John Poisal** and his colleagues said the addition of the Medicare drug benefit, slower projected growth in Medicaid, and slower growth in private health care spending are among the factors contributing to the trends.

"Although recent changes in health care spending growth have been modest, some of the most dramatic changes taking place are the shifts in payment distribution in Medicare, Medicaid, and the private insurance industry as Medicare Part D is fully implemented," Mr. Poisal said. "As the nation moves from more traditional sources of insurance, such as employer-based coverage, to more federal- and state-provided health care, we will continue to face tough questions about how we finance our health care bill."

Total Medicare spending growth

is expected to reach $417.6 billion in 2006 with the addition of the Part D drug benefit, up from $342 billion in 2005. Medicare spending growth in 2007 is expected to slow to 6.5%, in part because of legislated Medicare cuts in payments to managed care plans and reductions in payments to physicians. By 2016, Medicare's spending is expected to more than double from the 2006 level to nearly $862.7 billion.

Medicaid spending is expected to reach $313.5 billion in 2006, virtually the same as in 2005 as a result of a slower growth in enrollment and deceleration in payments to physicians and hospitals. Medicaid drug spending is expected to drop 36% between 2005 and 2006 as low-income recipients who are also eligible for Medicare start to get their drug coverage through Medicare Part D.

The analysts say that although Medicaid is seeing its lowest growth rate since the late 1990s, state and federal Medicaid spending is expected to rebound to 7.3% in 2007 and grow at an average of 8.1% per year throughout the rest of the projection period.

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Childbirth top health expense for undocumented immigrants

A look at health care needs of the growing number of immigrants in the United States raises questions about the financial wisdom of excluding them from routine health care, and especially prenatal care. A study published in the March 14, 2007, *Journal of the American Medical Association* found that the largest share of emergency medical expenditures in North Carolina is for pregnancy and labor complications for undocumented immigrants.

"Providing a dollar's worth of prenatal care can save $3 of postnatal care," said **Maria Youdelman**, director of the National Language Access Advocacy Project of the National Health Law Program in Washington, DC. "It's much more costly to use Emergency Medicaid to pay for prematurity and low birth-weight babies and postnatal complications."

Undocumented immigrants are estimated to account for 29% of the total foreign-born population in the United States. Researchers say that many "new growth" states that previously did not have large immigrant populations, such as North Carolina, are now getting many of the newcomers. And they may be less prepared to meet the immigrants' health care needs.

During the 1990s, the total foreign-born population in North Carolina grew by 274% and included some 300,000 undocumented immigrants by 2004. The researchers said the immigrants face many barriers to accessing health care, including federal law.

Undocumented immigrants and legal immigrants who have been in the United States for less than five years generally are excluded from Medicaid benefits. But they can receive emergency medical care, known as Emergency Medicaid, if they are children, pregnant women, families with dependent children, elderly, or disabled. For pregnant women, Emergency Medicaid covers labor but not routine prenatal care, leading to the cost paradox.

Researchers at the University of North Carolina analyzed administrative claims data for Emergency Medicaid and found that 48,391 people received emergency care between 2001 and 2004. In that group, 99% were undocumented immigrants, 93% were Hispanic, 95% were female, and 89% were between the ages of 18 and 40. The data show some 82% of Emergency Medicaid spending in 2004 was for childbirth and pregnancy complications, which accounted for 91% of hospitalizations.

About one-third of the remaining funds were spent on things such as injuries and poisonings, and large amounts also went for the complication of chronic disease, such as kidney failure.

The study found that the largest spending increases were among undocumented immigrants who were elderly and disabled.

Spending on pregnant women increased by 22% during the study period, by 70% for families with dependent children, and by 98% for the elderly.

However, the 16,106 patients who used Emergency Medicaid in 2004 represented only 5% of the total estimated undocumented immigrant population in the state. And Emergency Medicaid was less than 1% of the total state Medicaid budget, the researchers said.

"The availability of affordable culturally and linguistically appropriate primary care will be a critical determinant of both the effectiveness and cost efficacy of health care for immigrants in new growth areas," the authors concluded. ■

CMS backs off citizenship check for newborns

Responding to complaints about requirements under the Deficit Reduction Act that Medicaid recipients prove they are U.S. citizens, Centers for Medicare & Medicaid Services (CMS) officials said they are changing the requirement and will now say that all babies born in the United States whose deliveries are covered by Medicaid may remain eligible for Medicaid under certain circumstances for up to one year after their birth.

CMS acting administrator **Leslie Norwalk** said the Medicaid law provides that a child born to a mother receiving Medicaid will automatically be eligible for Medicaid for one full year if certain conditions are met.

Typically, according to CMS, newborn eligibility for Medicaid is "deemed" as long as the mother remains Medicaid-eligible and the child is a member of the mother's household. Under that deemed status, states don't make a new eligibility determination for the infant at the time of birth. Instead, eligibility is continued under the mother's status for the first year. After one year, the child's own eligibility must be established, including documenting citizenship.

Certain noncitizens, who ordinarily cannot be eligible for Medicaid, can be eligible for Emergency Medicaid services, including labor and delivery of a child *(see related story, p. 10)*. In a July 2006 interim final rule, CMS had said in such circumstances, the deeming process would not extend to infants born to mothers receiving Emergency Medicaid services. CMS now will issue a modified interim final rule allowing the deemed eligibility for an infant's first year of life. Documentation of eligibility would be required at redetermination in the same manner as for all deemed newborns, the notice said.

"Health care benefits are critical to the healthy development of newborn babies," Ms. Norwalk said in a statement. "We have heard the concerns raised and are taking action to ensure that newborns in similar circumstances are treated the same under Medicaid eligibility rules. We intend to modify the documentation requirements to put all babies born in the United States whose deliveries are covered by Medicaid on an equal footing."

Responding to the announcement, Sen. **Jeff Bingaman** (D-NM) said, "I'm glad the administration has taken this small step to fix a problem that it created. But we have a long way to go before the larger issue of citizenship documentation is resolved." And Sen. **Chuck Grassley** (R-IA), who has introduced legislation to ensure that all eligible infants born in the United States receive Medicaid coverage, said the CMS announcement was "a positive step" and added, "I look forward to watching CMS smoothly implement this rule."

Washington Gov. **Chris Gregoire**, who has filed a federal lawsuit against the citizenship requirements, said, "The Constitution could not be more clear: Babies born in the U.S. are citizens, regardless of who their parents are." ■

Correction

In the January 2007 *State Health Watch* story on the WebVMC Remote Nurse program in North Carolina, WebVMC president **Scott Sheppard's** name was spelled incorrectly. We apologize for the error.

This issue of *State Health Watch* brings you news from these states:

Clip files / Local news from the states

This column features selected short items about state health care policy.

Health insurance for all Minnesotans by 2011?

MINNEAPOLIS—A coalition of doctors, legislators, and consumer groups have proposed a sweeping universal health care system that would require all Minnesotans to have insurance and provide subsidies for those who couldn't afford it. The proposal sets a 2011 goal for mandating universal insurance. An estimated 380,000 Minnesotans—about 7%—are currently uninsured. By mandating insurance for everyone, the proposal resembles a plan by Massachusetts Gov. Mitt Romney, a Republican candidate for president, and goes well beyond proposals from Minnesota Gov. Tim Pawlenty and legislators for increased coverage. Pawlenty as well as some senators scaled back their proposals to cover all of the state's estimated 70,000 uninsured children.

The new bipartisan plan aims at insuring all adults as well as children.

But some business and labor organizations, including the Minnesota Chamber of Commerce and Minnesota Nurses Association, complained that the proposal requires insurance without containing costs that make health care unaffordable for many people.

The bill would require employers to report uninsured employees to the Revenue Department and collect a portion of their wages equal to insurance premiums as tax withholding. "This bill ... puts an incredible burden on businesses to report their own employees in Big-Brother fashion," said **Eileen Weber**, program coordinator for the Minnesota Universal Health Care Coalition. Supporters say the mandate would be mitigated by a sliding fee schedule that would set premiums according to a person's ability to pay.

Those unable to pay the full costs would receive a tax credit, enrollment in medical assistance programs or other subsidies. **Julie Schnell**, president of the Service Employees International Union in Minnesota, said she isn't convinced that the breaks would enable people to afford insurance. Proponents said that they had no good estimate on the cost of the program but that it could range from $300 million to $900 million a year. The proposal grew out of a task force of insurers and health care providers from Blue Cross and Blue Shield, HealthPartners, Mayo Clinic, and elsewhere.

— Minneapolis *Star-Tribune*, 3/8/07