John LOCKE FOUNDATION

SPOTLIGHT

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Get Control of Medicaid

Bringing Costs Into Line Will Help State Budget

Summary: States have three direct policy levers to control Medicaid growth: eligibility, services, and payments. North Carolina's mix of policies has led to some of the highest costs in the South, but the Blue Ribbon Commission on Medicaid Reform would make it even costlier. Tennessee and Mississippi, the two Southern states with higher per capita costs in 2000, have since made significant changes. Georgia and Virginia present different ways to reduce costs, while a 2001 report for the General Assembly presented largely unexploited savings.

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North Carolina has one of the most generous Medicaid programs in the South by almost any measure, with the highest level of payments per enrollee, third highest level of overall spending and payments per resident, and fifth largest enrollment in the 2000 federal fiscal year (the most recent comparable data available). The percent of people enrolled is slightly less than the 11-state average. Medicaid cost $600 per North Carolinian in 2000,[1] when state and local taxes together were roughly $2,700.[2] In the current state fiscal year (2004-05), Medicaid spending in North Carolina will total $8.2 billion — roughly $2.4 billion in state funds, more than $400 million from counties, and the remainder from the federal government.

Medicaid spending grew at an average 12.6 percent annual rate over the last quarter-century without even a single year's decline. In real terms, Medicaid spending in 2004 was more than seven times as high as in 1979. Enrollment grew at twice the rate of population in that time, up 219 percent, and only dipped in one year since 1984.[3] (Figure 1) While other state governments in the South and nationwide have proposed or implemented reforms to cut significant costs, the Easley administration included relatively modest changes in Medicaid in past budgets, with most reported "savings" consisting of midyear changes in cost estimates. The Blue Ribbon Commission on Medicaid Reform, created in 2003 to find cost-saving reforms in the program, instead offered ways to expand Medicaid.

States have three direct policy levers to control Medicaid spending, in addition to management and technology improvements. They can change eligibility standards, coverage standards, or reimbursement rates. Tightening any of these to save money is politically difficult, so the focus has been on improving management, implement-

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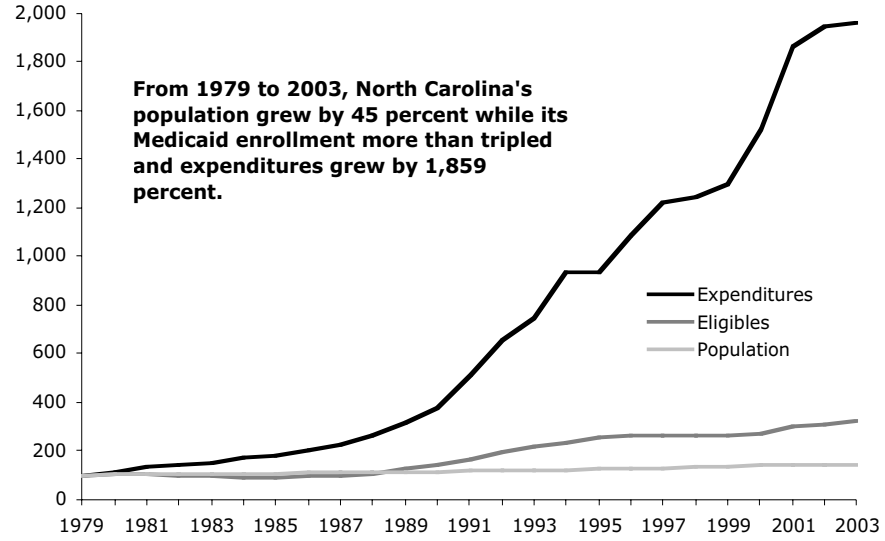
Fig 1: North Carolina Medicaid Growth, SFY1979-2003



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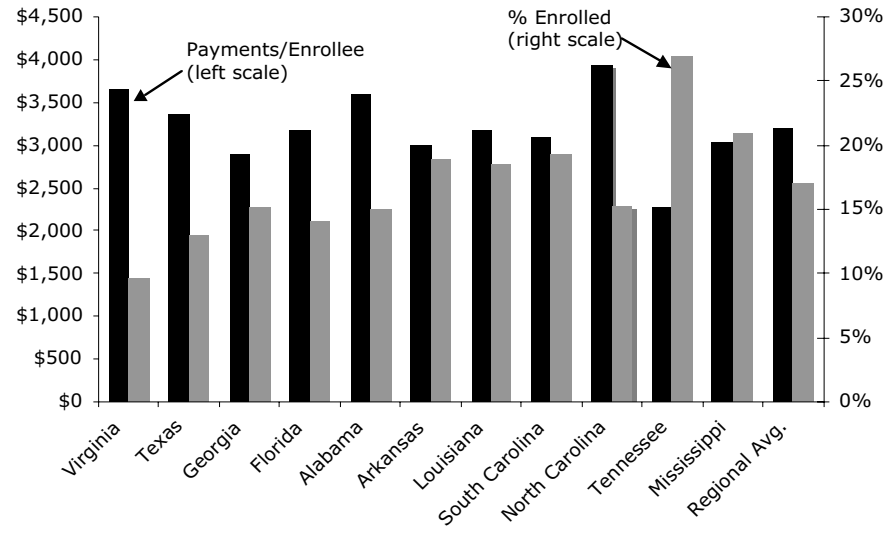
Source: *History of North Carolina Medicaid, 1970-2002* and *Medicaid in North Carolina Annual Report SFY 2003*

Fig 2: Payments/Enrollee and Enrollment Rates, FFY 2000



Note: Ranked by cost/resident - Mississippi highest, Virgina lowest
Source: www.statehealthfacts.org and author calculations

ing technology, and preventing fraud and abuse to find small savings. Potential changes in federal funding and increasing demands for the state to take the burden from counties, mean the state needs to find ways to achieve significant savings.

In 2000, only Tennessee ($614) and Mississippi ($635) spent more on Medicaid per resident than North Carolina's $600. Both states have since had to make large cuts in enrollment as their programs became unsustainable. (Figure 2 shows payments and enrollees by state, each influences cost per resident)

Tennessee's TennCare expansion of Medicaid gave it the lowest cost per enrollee in the South, but did so by enrolling over a quarter of the state's residents in HMOs, raising total costs. Insurance companies could not control costs and Republican Gov. Don Sundquist chose to push through a $900 million tax increase so the state could cover enrollees.[4] This was not enough to salvage the system. Democratic Gov. Phil Bredesen announced on January 10 his plan to save at least $575 million in the next fiscal year by cutting 323,000 adults from TennCare. The state is again transferring risk to managed care providers to reduce costs.[5]

Mississippi also followed the high enrollment model that lowers cost per enrollee but raises overall cost. Its Medicaid program ran out of money in 2002 and temporarily stopped payments to providers.[6] Last year Republican Gov. Haley Barbour cut 47,000 so-called dual eligibles who also qualify for Medicare from its aged and disabled program .[7] The state now also requires in-person interviews for Medicaid applicants.[8]

Georgia and Virginia offer two alternatives for controlling Medicaid expenses. Virginia was nearly as generous to its Medicaid enrollees, particularly those in long-term care, as North Carolina was, but had 10 percent of the population enrolled compared to 15 percent in North Carolina. As one member of the Virginia Senate quipped, "In order to qualify for Medicaid, you have to be very, very poor and very, very needy."[9] Nursing care facilities receive 27 percent of Virginia's Medicaid payments. If North Carolina reduced its Medicaid caseload by 33 percent to match the enrollment rate in Virginia, it would save roughly $800 million of state costs plus a combined $1.87 billion of county and federal costs.

Georgia's reimbursement methodology is not noticeably different from North Carolina's, but the state covered fewer services in 2003, particularly long-term care services. Possibly as a result of the limited availability of other services, nearly one-third of Georgia's Medicaid payments were for acute-care inpatient hospital services in 2000. Another potential factor is that Georgia uses managed care organizations that accept a set amount per person covered in addition to primary care case management like North Carolina's ACCESS managed care programs, under which a primary care physician receives a set amount to manage the recipient's care program and other payments are fee-for-service. Increasing costs and growing enroll-

ment plus a budget crisis have since led the state to take additional steps to control costs. Gov. Sonny Perdue is seeking bids from private insurers to cover 1 million Medicaid recipients in the state.[10] Matching Georgia's spending per recipient would save up to $630 million in North Carolina's state budget and another $1.3 billion for counties and the federal government.

Even with these four examples, a $1 billion-plus deficit going into FY 2005-06, a growing senior population, and an uncertain federal commitment to high Medicaid spending, the Blue Ribbon Commission on Medicaid Reform has made 15 proposals that would *increase* the state's obligations. Some earlier expansions of Medicaid managed to cut costs for the state and counties by bringing in federal funds. None of the Commission's proposals have this feature. The only cost saving proposed is for counties, whose contribution the Commission would shift to the state.[11] The General Assembly and the governor may be content with options that do nothing to save money, but the people of North Carolina deserve better.

A 2001 report by the Lewin Group (part of RTP-based Quintiles) for the General Assembly, originally intended simply to evaluate the state's management of Medicaid, nonetheless found that greater use of prior authorization for prescriptions and lower physician fees could save the state over $100 million a year without affecting service.[12] Still, much of those savings are still on the table. According to a study by the Urban Institute, in 2003 North Carolina's Medicaid fees for physicians were fifth highest in the nation—97 percent of Medicare fees compared to a regional average of 83 percent.[13] North Carolina's Medicaid physician fees in 1998 were just 85 percent of Medicare.[14] (Figure 3) These fees are high in part because of the state's ACCESS program, which funnels all decisions on care through the primary care physician. The state's prescription management program required prior authorization for just 12 classes of drugs. North Carolina also has one of the highest dispensing fees in the nation ($5.60 for brand, $4.00 for generic) in addition to payments for the drugs themselves.[15]

In addition to cutting eligibility, services, or reimbursement, the state can explore privatizing some coverage, providing ways for young families to take more responsibility for their own care through some combination of health savings accounts (HSAs) and vouchers for insurance, and encouraging purchases of long-term care insurance to limit the explosive growth in this area. The state can also take steps to introduce more typical market mechanisms to the entire healthcare system, too much of which has become dependent upon Medicare and Medicaid for survival. Most of the savings available by transferring cost to the federal government have been achieved. Other than the Medicare drug benefit, any future changes on the national level will also be made with an eye on cutting costs or transferring them to the states. Combine this with North Carolina's growing population of seniors through aging and migration, and it is clear that without reform Medicaid will continue to take a larger share of all expenditures.

— Joseph Coletti, Fiscal Policy Analyst

NOTES

[1] Author calculations based on data from www.statehealthfacts.org

[2] Author calculation based on data from http://taxfoundation.org/northcarolina/index.html

[3] Data from *History of North Carolina Medicaid Program: State Fiscal Years 1970 to 2002*, and *Medicaid in North Carolina Annual Report: State Fiscal Year 2003,* Division of Medical Assistance, N.C. Dept. of Health and Human Services.

[4] Mississippi Gov. Haley Barbour, "2005 State of the State Address," January 11, 2005.

[5] "State proceeds with TennCare overhaul," www.tennessee.gov/governor, January 10, 2005

[6] "Mississippi Medicaid runs out of money," *American Medical News*, March 18, 2002,

[7] "First Aid for Medicaid: Mississippi is committed to leave no PLAD behind," The *SunHerald*, June 30, 2004.

[8] Barbour, 2005 State of the State Address.

[9] "Bill aims to study health benefits," Richmond *Times-Dispatch*, January 14, 2005 .

[10] "State puts Medicaid out to bid", Atlanta *Journal-Constitution*, January 6, 2005 .

[11] "Blue Ribbon Commission on Medicaid Reform Final Report to the 2005 General Assembly of North Carolina," DRAFT.

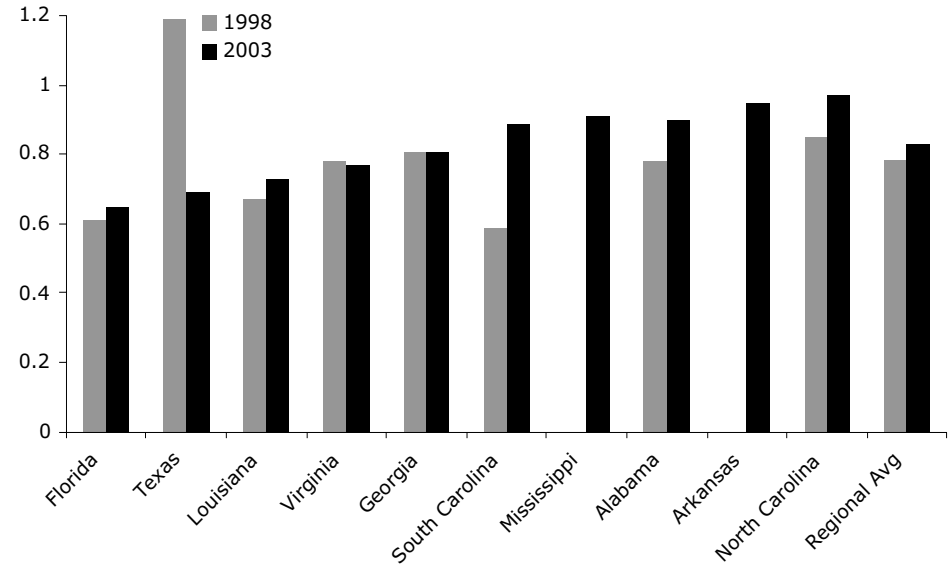
[12] *North Carolina Medicaid Benefit Study*, The Lewin Group, May 2001.

[13] Stephen Zuckerman, et al. "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation," *Health Affairs* Web Exclusive, 23 June 2004.

[14] Stephen Norton and Stephen Zuckerman, "Trends in Medicaid Physician Fees, 1993-1998," *Health Affairs*, July/August 2000.

[15] Jeffrey Crowley, et al. *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003*, Kaiser Commission on Medicaid and the Uninsured, December 2003.

Fig 3: Medicaid-to-Medicare Physician Fees Ratios, 1998 and 2003



Source: Urban Institute Medicaid Physician Fee Surveys, 1998 and 2003, cited in *Health Affairs*