

TOP STORY ■■■

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Health care budgets in critical condition

By Christine Vestal, Stateline Staff Writer

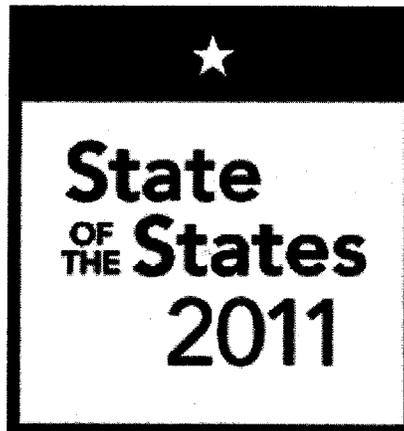
Ever since Congress passed a sweeping health care reform law last year, states have been split into two groups moving essentially in opposite directions.

Going one way are states like California, where leaders from both parties have embraced the federal law and even accelerated plans to implement it. Democrats in the Legislature last summer wasted no time writing a bill to create a health insurance exchange — a key element of the national framework — and Republican Arnold Schwarzenegger, who was then governor, signed it. California also sought and won a special waiver from the federal government to allow low-income adults now covered by state-funded health care programs to move into federally funded Medicaid plans prior to the 2014 effective date.

Going the other way are states like Arizona, where leaders wish the federal health care law would go away. First, Republican Governor Jan Brewer joined one of several legal battles aimed at overturning the federal law. Then, Brewer supported a successful ballot measure that rejects one of the core principles of the law, the so-called “individual mandate” requiring every American to buy health insurance. Now, with a gaping hole in her upcoming budget, Brewer is asking Washington for permission to scale back Arizona’s existing Medicaid program until health care reform takes effect in 2014.

This dual-track dynamic is likely to continue this year as states wrestle with two separate but related health care concerns. One is the many federal deadlines creeping up on states — dates by which the law requires them to make key decisions related to implementing health care reform. The other is the overwhelming cost of Medicaid. The state-run health insurance program for low-income people is eating up a fast-growing portion of state budgets that are entering the fourth — and probably worst — year of fiscal crisis.

The result is a messy situation chock full of contradictions. One of the federal law’s milestones for 2011 is for states to decide whether and how to launch their own health insurance exchanges. Every state but Alaska has begun planning to that end — even as 20 states continue fighting the federal law in court. Meanwhile, the budget crisis gives most states no choice but to try and squeeze cost savings out of Medicaid. Simultaneously, states will be deciding



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whether to deny costly services to Medicaid patients — as Arizona already has done with organ transplants — even as they plot a course toward universal coverage.

If there's one thing nearly all of the nation's governors agree on, it's that they'd like more flexibility from Washington on how to meet the massive health care demands they're now faced with. Although even the concept of flexibility means different things to different governors.

Many governors want flexibility to cut their Medicaid rolls by limiting who is eligible. That's a strategy that states have used to weather previous recessions, but provisions in the federal health care law, as well as the economic stimulus law, prevent them from doing it now. Last week, all 29 Republican governors who will hold office this year signed a letter to President Obama and congressional leaders asking them to drop that restriction.

Other governors mean something else entirely when they talk about flexibility. For example, Oregon's Democratic governor, John Kitzhaber, wants to be able to spend more Medicaid dollars on strategies that keep people healthy rather than waiting until they're sick to treat them. In a recent interview with *Stateline*, he cited the hypothetical example of an elderly woman with congestive heart failure living in an apartment without air conditioning. A heat wave could send that woman to the hospital, Kitzhaber says.

"The system today will pay for an ambulance to take her to the hospital and \$50,000 to cure her," Kitzhaber says. "It won't pay \$500 for a window air conditioner, which is really all she needs to stay in her home and out of the acute medical system."

Medicaid economics

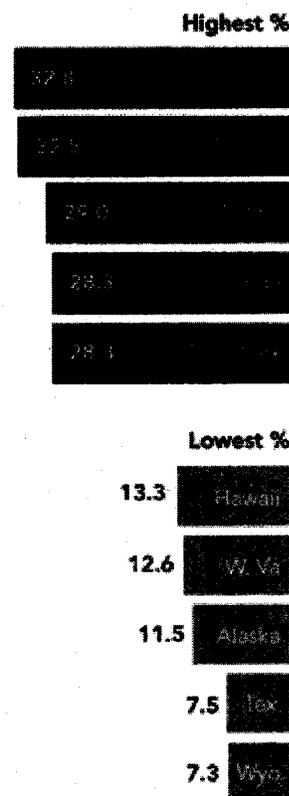
Last year, at a time when states made severe cuts in many programs, Medicaid spending grew by 8.2 percent. Medicaid has surpassed K-12 education as the largest portion of state budgets.

On average, the federal government pays 54 percent of all Medicaid bills; for poor states the federal share can be as high as 84 percent. Although states complain about the strings attached to Medicaid, no other federal program pumps as much money into state economies. According to the National Association of State Budget Officers, Medicaid accounts for nearly 43 percent of all federal dollars flowing into states.

The federal stimulus program added another \$137 billion to state Medicaid coffers to help make up budget shortfalls in 2009 and 2010. Last fall, Congress extended a scaled down

■ Medicaid keeps growing

In fiscal year 2010, Medicaid eclipsed K-12 education as the single most expensive item in state budgets. Nationally, the state-run health insurance program for low-income people consumes almost 22 percent of state spending. Here are the states that spend the highest and lowest percentage of their budgets on Medicaid.



Source: National Association of State Budget Officers

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version of the subsidy worth \$25 billion more, but that help gradually dissipates this year until it runs out entirely at the end of June.

When it's finally gone, states will have to find a way to replace about \$60 billion for the coming budget year. That pressure comes at a time when the weak economy and high unemployment rate have driven Medicaid enrollment to a record high.

Faced with this dire budget situation, states in 2011 are likely to turn to two places to cut Medicaid costs. Neither of them are particularly desirable.

One is payments to doctors and hospitals. States already have substantially cut back on reimbursement rates over the past two years, however. If fees go much lower in some states, health care providers will stop seeing Medicaid patients. Many doctors and hospitals already have fled the program.

The other thing states can cut is the types of services they cover. South Carolina, for example, plans to stop providing hospice care for the terminally ill. Massachusetts will no longer pay for dentures. North Carolina has stopped covering surgery for the clinically obese. In Texas and Nevada, lawmakers have toyed with the idea of dropping out of the Medicaid program altogether.

The problem is, nearly every state has cut their Medicaid programs to the marrow over the past two years, says Joy Johnson Wilson of the National Conference of State Legislatures. "States are in a real bind," she says. "Poor states that don't have any optional benefits to cut have nowhere to go."

The best scenario for states is that Medicaid rolls will gradually go down as the economy continues to recover and more of the unemployed get back to work, says Alan Weil, director of the National Academy of State Health Policy. Some also hope that as provisions of the federal health care law take hold, it will ease some of the burden on Medicaid. For example, small business tax breaks may push more employers to offer health insurance; kids up to age 26 may stay on their parent's insurance policies; and previously uninsurable people may sign up for new high-risk insurance policies.

The federal government is also offering grants to states to improve the efficiency of their health care systems. For example, the U.S. Department of Health and Human Services late last year awarded millions of dollars in demonstration grants to several states to pursue what is known as "medical homes" — a

Key dates for health care reform

The federal health care overhaul relies on states to implement much of the effort to get to near-universal coverage. Here are some key deadlines for states.

2010

- Must form pools to cover high-risk individuals or else have the federal government do it for them.
- Can opt-in early to expand Medicaid, in exchange for additional federal dollars.
- Can provide CHIP coverage to the children of some state employees.

2011

- Federal funding available for state-run health insurance exchanges, designed to help consumers and small businesses purchase insurance starting in 2014.
- Can apply for grants to test changes to tort litigation.
- Can allow Medicaid patients with serious chronic illnesses to designate a provider as a "health home" in exchange for federal dollars.
- Can apply for federal dollars for community health centers, as well as new programs supporting school-based health centers and nurse-managed health clinics.
- Termination of federal Medicaid dollars for certain hospital-acquired infections.

2012

- Can create demonstration projects to explore changes in the way Medicaid pays for services such as hospitalization and mental health.
- Must enhance collection and reporting of data on race, ethnicity, sex, language, disability status and underserved populations.

2013

- Must increase Medicaid payments to primary care doctors for two years, paid for by the federal government.

method of coordinating medical services that has been shown to improve health outcomes by accounting for all aspects of a person's health and lifestyle.

Insurance exchanges

Compared to their budget dilemmas, the decisions states must make about implementing health care reform seem relatively easy. The first agenda item is to decide whether or not to run a health insurance exchange — a virtual marketplace that would allow individuals and small businesses to compare public and private policies and premiums. Democratic governors see insurance exchanges as an opportunity to improve consumer choice and, in many cases, to update their legacy Medicaid information systems. Many Republican governors have signed on to the idea as well, with several conceding that the idea is worth pursuing even if the federal health care law is overturned.

The most controversial decision states will face in designing their exchanges will be whether to create an open, unfettered marketplace such as one already adopted in Utah. Another option is to negotiate prices and more tightly control the insurance industry, as Massachusetts has done under its three-year-old health care reform program.

Other decisions, such as whether to run the exchange through a state agency, a nonprofit or an independent commission also will require some deliberation this year. In many states, the biggest challenge in designing an insurance exchange will be finding the staff to do it after two years of widespread state government layoffs and furloughs.

The good news for states is that the federal government will pay the full cost of developing insurance exchanges. Once the exchange is up and running, however, states will be on their own.

Experts predict most, if not all, states will choose to develop their own exchanges — that's a decision that will require legislatures to pass a law to initiate. The alternative is to relinquish regulatory control over the state's insurance market. So far, every state except Alaska has accepted a \$1 million federal grant to do planning work related to the exchanges.

The next step will be for states to submit proposals and get federal project funding starting in March. Then will come the usual challenges of putting together a brand new program. Small states will be challenged to pull together a large enough pool of providers to successfully bid for low premiums. Meanwhile, large states may find the enormity of the project and the short time frame daunting. A federal audit of the state exchanges is scheduled for 2013.

Even as states implement the exchanges, however, the backlash against the federal law is bound to go on. The key flash point is the individual mandate. In addition to Arizona, six states — Georgia, Idaho, Louisiana, Missouri, Oklahoma and Virginia — already have approved

2014

- All citizens required to have insurance.
- Must expand Medicaid eligibility to at least 133 percent of the federal poverty line, with the federal government paying for initial costs associated with the coverage.
- Can create a basic health plan to cover those just above the new Medicaid eligibility level.
- Must operate state-based health insurance exchanges, with federal tax subsidies going to middle-income people to help pay premiums.
- Must have new standards, reporting requirements and insurance regulations.
- The amount of federal dollars going to state hospitals that regularly treat a disproportionate amount of uninsured will be reduced.
- Can apply to be one of 10 states with pilot wellness programs that offer rewards to individuals with insurance.

2016

- Can form health care choice compacts with other states, allowing insurers to sell policies in states participating in the agreement.

*Includes information from Kaiser Family Foundation health care timeline.

laws or constitutional amendments making it illegal to require anyone to purchase an insurance policy.

More states are expected to take up the issue this year, according to the American Legislative Exchange Council, which developed model legislation aimed at blocking implementation of national health care reform. In addition, the states' lawsuits claiming that Congress and the Obama administration overstepped their authority by requiring individuals to purchase health insurance will continue moving through federal courts. Most observers expect the U.S. Supreme Court will eventually weigh in on the matter.

Opponents and supporters of the health care law agree that if the individual mandate were struck down, most other aspects of its approach to achieving near universal coverage also would unravel. For states, that would mean that the debate over whether or how to change the health care system would begin all over again.

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