States Eye Medicaid Cuts As Cure for Fiscal Woes

Facing their worst fiscal crises in decades and required by law to balance their budgets, states are taking a series of difficult steps to cut back on health coverage for low-income residents. These policy changes could roll back much of the recent progress made in expanding coverage for low-income children and their families and in easing the traditionally cumbersome process of applying for publicly subsidized coverage. With millions of Americans looking to programs such as Medicaid and the State Children's Health Insurance Program for their care, the adverse impact of these state actions on access to reproductive health care could be significant.

By Rachel Benson Gold

Medicaid, the massive federal-state program that provides health coverage to 47 million of the nation's poorest residents, is a "counter-cyclical" program—by its very design, it grows as economic conditions deteriorate and more people slip under state-set income-eligibility thresholds. Although that means that more Americans are eligible for coverage when they need help the most, it also means that the program becomes more expensive to the federal and state governments at exactly those times when they can least afford it. That is precisely the situation now occurring during this prolonged period of economic stagnation ("Post-Attack Economic Woes Create Challenges for Family Planning Advocates," *TGR,* December 2001, page 8).

As the nation's economic slump has persisted, Medicaid enrollment has soared. According to the Kaiser Commission on Medicaid and the Uninsured, program enrollment has grown by an annual rate of about 8% in 2002 and 2003, bringing Medicaid expenditures up sharply. Medicaid now accounts for about 20% of state spending, and is second only to education as the largest component of state budgets. This cost, along with mounting calls from the states for more flexibility in designing and operating their Medicaid efforts, has led to a drive to reshape the program.

Fundamental change to Medicaid would have enormous implications for reproductive health care. Medicaid is the single largest source of funds for family planning services and supplies, and the federal Medicaid statute includes a series of important provisions specific to family planning that are designed to facilitate enrollee access to this care (see box). In addition, through a series of steps in the 1980s, Congress greatly expanded eligibility for Medicaid coverage of pregnancy-related care: Each year, the program now pays for nearly four in 10 U.S. births. Finally, state Medicaid programs routinely cover a range of other preventive reproductive health services, such as mammograms and Pap tests, as well as STD (including HIV) testing and treatment.

More than six million women of reproductive age rely on Medicaid for their basic health care. Despite provisions in the 1996 federal welfare reform law designed to mitigate its impact on Medicaid, enrollment in the program fell sharply in the wake of the legislation that delinked Medicaid and welfare for eligibility purposes. The proportion of women of reproductive age enrolled in Medicaid began to grow again in 2001 with the overall slide in the U.S. economy. By that year, one in 10 reproductive-age women looked to Medicaid for their care (see chart).

THE FEDERAL MEDICAID STATUTE INCLUDES SEVERAL KEY PROVISIONS SPECIFIC TO FAMILY PLANNING SERVICES AND SUPPLIES

Every state Medicaid program must include coverage of "family planning services and supplies to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies." Whereas prescription drugs in general are covered at the states' option, contraceptives are included under the family planning mandate and, therefore, are required for all state programs.

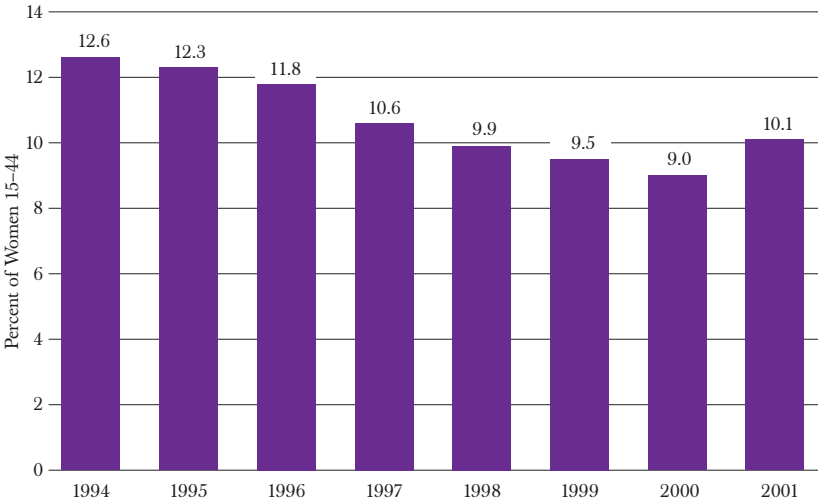
Although states are generally reimbursed by the federal government for 50–75% of the cost of providing covered services to Medicaid recipients, the federal government contributes 90% of the cost of providing family planning services and supplies in all states.

For most services covered under Medicaid, states may require enrollees to incur "nominal" out-of-pocket costs. Cost-sharing for family planning services and supplies is prohibited, however, regardless of requirements placed on other services, drugs or supplies.

States may require Medicaid recipients to enroll in managed care plans and to obtain care from providers affiliated with those plans; however, an exception is made for family planning: Most Medicaid managed care enrollees may obtain family planning services and supplies from the provider of their choice, even if that provider is not affiliated with the enrollee's managed care plan.

Medicaid Enrollment

The proportion of women of reproductive age enrolled in Medicaid fell in the years after welfare reform, but increased as economic conditions worsened nationwide.



Source: The Alan Guttmacher Institute, tabluations of data from U.S. Census Bureau Current Population Surveys, 1995–2002. *Note:* Beginning in 2001, the CPS specified that data include SCHIP enrollees.

The State Children's Health Insurance Program (SCHIP), a newer arrival on the scene, was enacted by Congress in 1997 primarily to provide coverage to children in families with incomes up to 200% of the federal poverty line. In the flush years of the late 1990s, several states expanded their programs to include the parents of eligible children as well. In contrast to the open-ended Medicaid program, states receive a fixed annual federal allotment for SCHIP. The program now covers 5.3 million individuals and is an important source of coverage for enrolled teenagers needing reproductive health services. As initially implemented by the states, SCHIP programs routinely covered basic gynecologic care, screening for STDs and pregnancy testing; almost all covered the full range of the most commonly used contraceptive methods ("Expanding Eligibility and Improving Outreach under CHIP," *TGR,* June 2001, page 6).

Restructuring Medicaid and SCHIP

Earlier this year, the Bush administration unveiled a proposal to revamp Medicaid by ending the entitlement to care that has been the cornerstone of the program since its inception in the 1960s. Under the entitlement structure, all individuals in a state who meet the program's eligibility requirements are entitled to enroll. States receive reimbursement for a predetermined proportion of their total costs—a flexible system that allows federal funds to increase as enrollment, and therefore cost, increases. In contrast, the administration's plan would effectively combine Medicaid and SCHIP into a single program and give states a fixed annual allotment for both—an arrangement that would leave states at risk for any costs exceeding the allotment. In exchange, states would be given much greater latitude to determine which benefits would be covered and which populations would be served.

The administration—clearly expecting states to rally around the proposal because of its greatly enhanced flexibility—appeared caught off guard by states' tepid response because of the federal funding cap. Instead of endorsing the plan, the National Governors Association created a task force of 10 governors, equally divided between Democrats and Republicans, to develop recommendations. After meeting several times, the panel disbanded without being able to reach an agreement—a development that seems to have taken much of the wind out of the drive for Medicaid "reform," at least at the moment.

In the interim, Congress did step in and provide some short-term fiscal assistance to the cash-strapped states. As part of the tax-cut legislation this spring, Congress provided $10 billion to the states in the form of a temporary increase in the proportion of Medicaid costs reimbursed by the federal government.

Although this measure does provide welcome relief, the states are widely acknowledged to be facing their worst fiscal crises since the middle of the last century. And to further compound the problem, states (with the lone exception of Vermont) are prohibited from running deficits and are required by law to balance their budgets. With Medicaid being such an enormous share of state spending, it is a clear target for the increasingly desperate states.

Program Cuts

As national economic conditions deteriorated in recent years, states first turned for help to the "rainy day" funds they had accumulated during better economic times and to one-time sources, such as revenue available through the states' legal settlement with tobacco companies. But by state fiscal year 2003 (which began in July 2002 for most states), those sources were close to depletion, and states looked to their Medicaid and SCHIP programs for savings. Most often, last year's moves focused on controlling prescription drug costs or adjusting the reimbursement paid to providers, according to an analysis by the Kaiser Commission.

During this year's legislative season, as states moved into their budget cycles for fiscal year 2004, they did so staring at a collective budget shortfall in the neighbor-

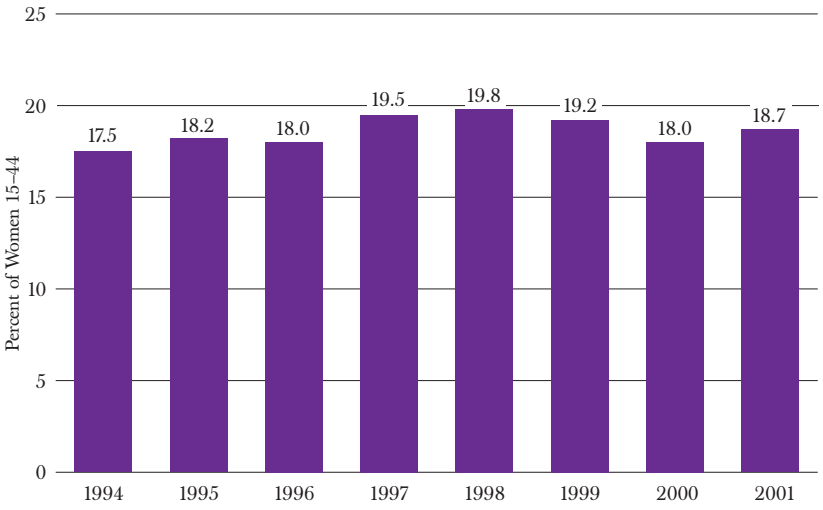
hood of $70 billion. An analysis by the Center on Budget and Policy Priorities of governors' initial budget proposals predicted that the cuts "adopted or proposed in 22 states would lead to the elimination of Medicaid, SCHIP, or related public health insurance coverage for 1.7 million people, if all the proposals are adopted."

Although many of these proposals were rejected outright or modified significantly, and six states were still unable to agree on a budget by the start of their fiscal year, several states enacted deep cuts to their Medicaid and SCHIP programs this spring. The changes that are most likely to affect the degree to which low-income Americans will be able to rely on Medicaid and SCHIP for reproductive health care fall into four major categories: reductions in eligibility, changes in enrollment procedures, cuts in provider reimbursement and limitations on covered benefits. The following outlines some of the measures that have been adopted.

Eligibility ceilings. SCHIP has been on the front lines this year, with legislators in both Texas and Missouri attempting, ultimately unsuccessfully, to eliminate the program altogether. Other states have moved to trim eligibility for the program. For example, Alaska scaled back its income eligibility ceiling for SCHIP from 200% of poverty to 175%. Connecticut lowered the income ceiling for parents from 150% of poverty to 100%, although legislation to block implementation of this change has been filed.

Uninsured Women

After falling for several years, the proportion of women of reproductive age with no health insurance coverage has again begun to climb.



Source: The Alan Guttmacher Institute, tabluations of data from U.S. Census Bureau Current Population Surveys, 1995–2002.

States have also targeted eligibility for Medicaid. For example, Alaska imposed a freeze on its income-eligibility level for Medicaid, so it will no longer rise with inflation, and reduced the income ceiling for pregnant women from 200% to 175% of poverty. According to a report in the *New York Times,* Texas is reducing Medicaid eligibility for pregnant women from 185% of poverty to 158%.

In addition, at least two states have eliminated some Medicaid coverage for immigrants. When Congress passed welfare reform in 1996, it eliminated federal Medicaid reimbursement for many immigrants. Several states continued to use their own funds to make up at least part of the gap ("Immigrants and Medicaid After Welfare Reform," *TGR,* May 2003, page 6). However, Colorado and Minnesota ended state-funded coverage for immigrants this year, although implementation of the Colorado provision has been blocked by a court order.

Enrollment procedures. States have also taken steps to tighten enrollment procedures, effectively turning the clock back on an effort begun in the 1980s to make the process of enrolling in and retaining coverage under Medicaid less daunting. Some of the most severe changes to enrollment are those adopted by Texas in its 2004 budget, which reduced the amount of assets a family could have and still qualify for Medicaid and imposed a 90-day waiting period for enrollment. The state also scaled back the ability of families applying for SCHIP to mail in their applications rather than have an in-person interview.

States such as Minnesota, Texas and Washington eliminated 12 months of so-called continuous Medicaid eligibility, which provides a period of coverage regardless of fluctuations in family income; Connecticut took parallel steps in its SCHIP program. These states are now requiring that income be verified every six months, a move that could result in the removal of large numbers enrollees from coverage.

Provider reimbursement. Several states have attempted to freeze or even reduce the amount that Medicaid providers such as hospitals, nursing homes and doctors are reimbursed for care given to Medicaid enrollees. One of the most onerous proposals was in California, which was facing a budget deficit of $38 billion—an amount greater than the entire annual budget of any other state except New York, according to the *Washington Post.* The budget initially submitted by Gov. Gray Davis (D) included a 15% cut in reimbursement to most health care providers, including family planning clinics, to be phased in over a two-year period. Planned Parenthood Affiliates of California estimated

that a cut of this magnitude would result in a loss of $45 million to family planning providers in the state in a single year. The cut was deleted from the proposal as it moved through the legislative process, although California is one of the states that had not yet adopted a final budget by July 1.

Benefit limits. States have been looking at a variety of ways to limit the actual benefits covered under Medicaid and SCHIP. With key services mandated under federal law, reproductive health has largely been shielded from much of this effort. Most often, states have targeted benefits such as prescription drugs and dental, vision, mental health or home health care for reduction. The one case in which family planning was the specific target of a reduction occurred last year in Missouri. In mid-2002, the state scaled back its demonstration program providing family planning to women for two years following a Medicaid-funded birth; the program now covers postpartum family planning for only one year.

Prospects for Change

As dire as the budget picture is at the state level, some advocates are finding reason to be cautiously optimistic. Leighton Ku of the Center on Budget and Policy Priorities argued in a recent paper that the $10 billion in fiscal relief for state Medicaid programs should alter states' calculations. The fiscal relief funds will be dispensed as a temporary hike in the federal reimbursement paid to states to cover the costs of serving Medicaid enrollees. Because this reimbursement varies by state, Ku asserts that the cost of Medicaid to the states will be 6–13% lower than previously thought, at least for the next several quarters. Moreover, the higher federal payment will make any savings from cuts lower than anticipated. Ku argues that this should encourage states not to undertake additional cost-saving measures.

However, many states already have made serious cuts to their Medicaid efforts, as previously discussed. Many of these cuts have eliminated critical services or placed them out of reach of some recipients. Still others have resulted in a loss of coverage, either directly by trimming enrollment or indirectly by making the enrollment process more cumbersome. With women comprising 70% of Medicaid recipients over age 15, the impact on women could be enormous, and access to critical care, including reproductive health services, could be seriously reduced.

All of this comes at a most unfortunate time, when the number of Americans without health insurance is rising. In 2001, 11.5 million women of reproductive age—19% of women between the ages of 15 and 44—were uninsured (see chart). With additional aid from Congress unlikely, at least in the near term, health care advocates can only hope that Ku is right and that states will find additional cuts unnecessary and, perhaps, even review the wisdom of the measures already undertaken.