An Aging Population Challenges U.S. State Budgets And Renews Interest In Health Care Reform

An aging U.S. population is challenging state governments to manage their own obligations relating to employee and retiree benefits, but also their substantial funding obligations for Medicaid, while balancing other spending demands.

Not only are U.S. states large employers that will face a surge in payments related to pension, post-retirement health care costs, and additional benefits as retirements accelerate, they also have other unique funding responsibilities that will require significant future resources.

Providing health care for the poor, the aged and the disabled, and also grappling with the uninsured population have presented budget challenges for all states. Most states are required to balance their budgets annually, and as a result, have aggressively turned to health care cost containment initiatives and reform efforts as a means of managing competing spending pressures.

How these funding challenges are planned for and managed will play a role in budget balance and flexibility for many states, which are important considerations in the credit review process.

States Are Bracing For Retirement Surge And Rising Health Care Costs

Fortunately, most states understand their economic and demographic profiles and their individual health care environment, and have found creative ways to control the costs of big programs such as Medicaid, which provides comprehensive health insurance to more than 55 million low-income individuals in the U.S. Since Medicaid's creation in 1965, states have shared its costs with the federal government. However, federal and state Medicaid budget burdens have grown, and this trend is expected to continue, and states have turned to
enrollment and eligibility caps, plus tough limits on payments to health care providers, to contain Medicaid spending.

In many ways, the forces that have led to such limits also affect private employers. In numerous cases, health insurance for employees of small companies has become less available and more expensive. This in turn has pressured health care providers, especially physicians and hospitals, who have effectively argued for greater state involvement from a policy and financial standpoint.

This has underlined the need for more widely available health insurance as an essential element in both addressing an important public health problem (the uninsured), and for helping to shore up the health care system. Otherwise, the uninsured will continue to rely on very expensive hospital emergency rooms for basic care.

The Looming Measurement Of OPEB Liabilities

State and local governments are large employers with 15.9 million employees and for the most part provide them with not just pensions, but with other post employment benefits (OPEB) such as health care, dental, vision, life insurance, and other benefits. While states have built up income earning assets over time to fund their pension costs on an actuarial sound basis, this has not been the case for other retiree benefits. Governments have mostly funded OPEBs out of their annual operating budgets as expenses are incurred with no accounting for the future liabilities of these benefits.

GASB will change that. Effective in the fiscal year after Dec. 15, 2006, governments with annual revenues in excess of $100 million must disclose their annual cost of OPEBs using the accrual method of accounting. States will be subject to this reporting requirement in fiscal 2008, and many already are in various stages of compliance.

While such liability isn't new, the quantification of the future costs of these benefits is new. The disclosure is likely to lead to an examination of the ability of a government to maintain the current benefit levels from a cost standpoint. There is no requirement to fund the liabilities at this time, but the costs will clearly escalate as the state and local government work force retires at an accelerating pace. The hope, however, is that the new GASB requirements will lead to better financial planning for these liabilities plus realistic commitments for future benefits.

Table 1

| State Medicaid Spending As A % Of Total State Expenditures |
|----------------------------------|-------|
| Highest % of Total Expenditures  |
| Tennessee                        | 35.2  |
| Mississippi                      | 32.2  |
| Missouri                         | 32.0  |
| Pennsylvania                     | 31.3  |
| Maine                            | 31.3  |
| Lowest % of Total Expenditures   |
| Wyoming                          | 4.6   |
| Hawaii                           | 10.8  |
| West Virginia                    | 12.0  |
| Alaska                           | 12.8  |
| Virginia                         | 13.6  |
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Table 1
State Medicaid Spending As A % Of Total State Expenditures (cont’d)
Source: National Association of State Budget Officers - The Fiscal Survey of States (June 2006)

Medicaid Moves To The Forefront Of State Spending
Medicaid has become the biggest component of state spending, according to the National Association of State Budget Officers (NASBO). (Chart 1 shows that, on average, Medicaid represented 22.3% of state spending). Each state determines its own eligibility rules, roster of services, and reimbursement levels, subject to federal minimums, and there is wide variation. Medicaid thus ranges from a low of 4.6% of state spending in Wyoming to a high of 35.2% in Tennessee (see table 1, "State Medicaid Spending," which shows the top 5 and bottom 5 states with respect to spending as a % of budget). The Congressional Budget Office (CBO) estimates that state and federal spending for Medicaid will exceed $300 billion this year to serve 60 million people, or 20% of the U.S. population. Program costs have accelerated faster than inflation – rising an average 7.1% annually from 1975-2002, thanks to growing enrollment and medical price inflation, and this trend is expected to continue.

That will be thanks in part to an aging population. Medicaid serves a broad range of people, including low-income children and adults, disabled children and adults, and the elderly living in institutions — nursing homes, many of whom are eligible for both Medicare and Medicaid and are among the most costly caseloads. Medicare generally doesn’t fund extended nursing home stays. The Congressional Budget Office estimates, 70% of the cost of Medicaid goes toward care of the elderly and disabled, who represent only 25% of enrollments. As aging trends accelerate, total program costs will as well — disproportionately. From 2007-2016 the aged enrollment is expected to increase by 2.6% annually, more than double the 1% growth rate for total enrollees (see table 2 for growth enrollment projections).
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Table 2

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Source: Congressional Budget Office Testimony - Medicaid Spending Growth and Options for Controlling Costs before the Special Committee on Aging in the United States, July 13, 2006.

If no changes are implemented, federal spending on Medicaid could increase to 5.9% of Gross Domestic Product in 2050 from the current 1.5%. State spending would be in addition. Federal costs for Social Security, Medicare, and Medicaid combined would rise to nearly 28.5% of GDP by 2050 from the current level of 1.5%.

The outlook for federal funding related to Medicaid is soft. The Deficit Reduction Act of 2005, signed into law on Feb. 8, 2006, contains significant changes to Medicaid policy, most of which are aimed at reducing federal Medicaid spending. While these changes have not resulted in significant reductions yet, federal plans now don’t include boosting Medicaid funding. To avoid getting stuck with an escalating tab, states are aggressively seeking to rein in Medicaid costs with more efficient delivery of health care.

Total Medicaid Spending - Federal And State Share

Source: Pew Center on the States - Special Report on Medicaid.

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States Seeking Health Care Reform

States must seek federal waivers to amend their Medicaid programs, which they’re starting to do. Many of these reforms are comprehensive and expand insurance coverage (and costs) in the short run in hopes of lowering costs over time. Here’s what some key states are doing:

Florida: An unprecedented restructuring of state Medicaid programs

U.S. Department of Health and Human Services (HHS) Secretary Michael O. Leavitt and Florida Gov. Jeb Bush announced on Oct. 19, 2005, that the federal government had approved Florida’s Medicaid waiver application, which the Florida legislature subsequently approved. The legislation requires Florida’s Agency for Health Care Administration to develop an implementation plan with budgetary estimates through fiscal 2010. A pilot program began on July 1, 2006, in Duval and Broward counties, and if all goes well will become statewide by 2011 with legislative approval. The goal is to reduce or just hold down Florida’s Medicaid costs, which had climbed to $15.3 billion in fiscal 2006 from $10.2 billion in fiscal 2000.

The plan is to transform Medicaid into a premium-based defined contribution program administered and funded by the state, which will set aside a specific amount for each enrollee. The amount of the assistance will be risk-adjusted to reflect the medical needs of each participant.

Additionally, Florida will establish a maximum benefit limits similar to those in private insurance. All Medicaid participants will receive catastrophic coverage. The plan gives consumers a choice of benefit plans, and is intended to provide greater flexibility in structuring insurance programs. Medicaid premiums deposited into flexible spending accounts may be saved and used in the future to help participants purchase employer sponsored insurance. It is early in the process to determine how successful the state’s initiative will be in containing costs. But it is an unprecedented experiment that other states will watch closely.

California: Medi-Cal reform is a work in progress

California’s ongoing fiscal challenges, coupled with rising costs of care for the state’s large low-income, uninsured, and aging populations, has led to increased focus on reforming the state’s Medi-Cal program and leveraging federal funding. Medi-Cal expenditures are the California’s second-largest general fund expenditure, surpassed only by K-12 education.

Approximately one in five Californians receives care through the Medi-Cal program. As in many states, 25% of the people covered are seniors and the disabled, who account for more than half of program expenditures. The cost of caring for the elderly is expected to continue to rise more rapidly than the cost of helping low-income children and families. In fiscal year 2006-2007, total program expenses are expected to total $35.1 billion with $13.8 billion coming from the state General Fund.

Legislators, the governor, and others are focusing on reforming Medi-Cal and protecting the uninsured. While there appears to be consensus as to the need for changes in funding and care delivery, there is less agreement on what course to take. Gov. Arnold Schwarzenegger proposed a sweeping Medi-Cal “redesign” in early 2005, advocating migration of children, the elderly, and disabled into a new managed care Medi-Cal program. He also proposed changes in the funding of safety net hospitals (through a so-called Section 1115 waiver), changes in the benefits, and patient eligibility cost-sharing, among other initiatives.
The thirst for comprehensive reform remains. However, the governor vetoed legislation aimed at providing universal coverage, which proposed that large businesses contribute to funding care for the uninsured, as well as proposals for a single payer, government-run health care system.

The new section 1115 waiver would broaden enrollment in Medi-Cal managed care, expand coverage to uninsured individuals, and protecting funding for safety net hospitals through the creation of a Safety Net Care Pool (essentially replacing the existing disproportionate share hospital (DSH) funding). The waiver effectively provides a fixed allotment of $766 million per year in federal funding for safety net hospitals, which serve a large Medicaid and uninsured population, replacing the old “SB 1255” Emergency Services and Supplemental Payment Program funds. Each year, $180 million of these funds would be contingent on the state’s meeting of specific milestones related to the 1155 waiver.

The waiver is supposed to be implemented with no net increase in state general fund costs. Contingent funds are tied to the expansion of managed care to the aged/blind/disabled population (during the first two years) and expansion of coverage to the uninsured (during years three through five). The waiver program is also supposed to protect funding for both governmental and private hospitals that now rely on DSH funding.

While the state appears to be effectively leveraging federal funds, some concerns remain. Funding for the non-federal portion of Medi-Cal inpatient expenditures in public hospitals is shifting from the state general fund to California’s counties, and limitations on intergovernmental transfers further complicate the funding formula. Additionally, Safety Net Care Pool funding is capped each year, meaning that the state cannot receive further federal funding should the number of uninsured increase, or the use of services increase substantially. Furthermore, other aspects of the plan are so complex that it remains to be seen what the net impact will be on health care providers and the state’s budget.

Maine: A homegrown plan to help the uninsured

The Maine Legislature passed a comprehensive health care reform initiative in June 2003 known as the Dirigo Health Plan (DHP), named for the state motto, which means, “I lead.” The need for reform was clear: Maine’s economy was slowing and its residents spent more of their income on health care than the citizens of 45 other states (Maine ranks second in the nation in personal health care spending as a percentage of the Gross State Product). Even so, more than 130,000 (10%) of Maine’s 1.3 million citizens lacked health insurance coverage.

DHP is a comprehensive reform initiative designed to contain health care costs, improve quality, and ensure access to coverage for all Maine citizens by 2009. DHP further directs the governor to issue a biennial state health plan to be drafted after public hearings theoretically lead to a consensus.

Also, the state’s certificate of need program, used to control capital costs, would limit approved projects to those meeting the goals and budgets in the health plan. These groundbreaking measures reflected, in part, the need to control health care costs in a state that is largely rural and poor, and has few large employers that can shoulder the burden if federal reimbursement levels are inadequate to support the state’s hospitals.

Fiscal 2004 was the first year under DHP for Maine’s 39 acute care and specialty hospitals, which were called upon to comply with voluntary cost and operating margin limits that are established annually. DHP also recommended that a study be done of the feasibility of establishing Dirigo Health guidelines, including disease management protocols.
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Substantial portions of DHP remain to be fully implemented and funded, an envisioned high-risk pool for high-cost cases and certain diagnoses. There is considerable debate about the funding mechanisms necessary to implement the plan fully. In addition, the measurable savings since implementation are in dispute.

Only time and the availability of better data will tell whether DHP will be a true success. But the state and its governor, who has been one of the leading proponents of the plan, is to be commended for mounting a daring effort at a time when the federal government appears largely absent from the debate about how to control health care cost spending and cover the uninsured.

Massachusetts: A plan for universal health insurance for all commonwealth citizens
Like a number of states, Massachusetts is trying to both control its health care costs and broaden coverage for its growing uninsured population. The sweeping health care reform bill that was signed into law in April 2006 requires that all commonwealth residents obtain health insurance by July 1, 2007. The goal of the bill is to provide universal health insurance coverage through a combination of state and individual funding, plus a mandate that employers with more than 10 employees provide a basic level of health insurance or face financial penalties.

The success of this program appears to depend on the level and sustainability of subsidies the state will provide, the ability of the state’s insurance companies to deliver policies at an ‘affordable’ price, and the willingness of the current uninsured population to shoulder modest premiums and co-pays.

In addition to legally requiring all Massachusetts residents to carry health insurance, the law secured $385 million in federal Medicaid waiver dollars that were in jeopardy if the methodology governing the commonwealth’s existing uncompensated care pool (the Pool) wasn’t changed to meet federal approval.

Currently, health care providers pay an assessment to the Pool and are reimbursed for the cost of uninsured care in a variety of ways. The Pool reimburses uninsured care primarily for inpatient services, whereas Medicaid and the new “affordable” coverage are expected to reimburse for inpatient, outpatient, and physician services. In the future, in theory, individuals will receive preventive care, which should help reduce the need for more expensive services in future years and thus, over time reduce state expenditures.

A quasi-governmental entity known as the Commonwealth Health Insurance Connector has been established to implement the law, which allows for insurance premiums to be paid pre-tax, and for portability for individual coverage. In addition, a new Health Care Quality and Cost Council will publish updated cost data so that consumers can make informed purchasing decisions on medical care. The council will also set performance and cost goals for providers, pharmacies, and managed care organizations (payors).

The current uninsured population in Massachusetts is estimated at 500,000, or approximately 8% of all citizens. Under the new law, an estimated 95% of Massachusetts’ uninsured population will have health insurance by 2009.

We believe that the law has the potential to provide savings to hospitals and health systems (providers) over time, but perhaps not until it’s fully implemented. For starters, providers will continue to pay assessments to the Pool, which will shift the use of those funds to subsidize insurance for individuals earning less than 300% of the federal poverty level.
Providers also expect Massachusetts to incrementally add $90 million per year in Medicaid reimbursement dollars for fiscal years 2007 through 2009 to cover its existing Medicaid population and to provide for those individuals added through the law’s more lenient eligibility rules. Thus, state costs will rise initially.

Beginning on July 1, 2007, providers expect to see increased reimbursement from payors that offer “affordable” health insurance options — reimbursement offset by a decrease in the amount of uncompensated care provided. An uncertainty is whether the poor will be able to afford the new policies created for them, and whether low insurance premiums and state subsidies can be sustained over time.

Our greatest concern is that the law won’t effectively curb the cost of covering the uninsured. Should that be the case, any additional financial burden on providers could damage their profitability, potentially affecting credit quality.

From a state perspective, should the scope of the effort expand significantly, eligibility requirements change, or federal funding (Medicaid) not materialize as envisioned, significant pressure could be exerted on the Massachusetts general fund. How the commonwealth would manage increased costs, whether by using reserves, other spending offsets, additional taxes, or some combination is a question that can only be answered as the law is further implemented and is deemed either successful or shortsighted.

As promising as it might seem, it’s unlikely that the Massachusetts experiment will be viable as a national solution, especially as it raises costs in the near term. Also, Massachusetts has the relatively unique demographic of a low uninsured population (8% compared with the national average of 18%) and an existing pool of $650 million that’s dedicated to lowering the cost of health care for the uninsured.

**Vermont: Seeking more operating flexibility for its Medicaid liabilities**

Health care and education appropriations, along with Medicaid, continue to account for a growing share of Vermont tax dollars. In fact, Medicaid appropriations have grown by an average of about 10% annually since fiscal 1999.

Vermont’s Medicaid benefits are more generous than in other states, and cover roughly 25% of the state’s population, vs. 20% of Massachusetts residents. Partly, that’s because Vermont has expanded coverage beyond traditional Medicaid-eligible populations to cover children and working-class families. Higher costs reflecting robust enrollments, expanded services, and medical inflation have left Vermont struggling to pay 40% share of the Medicaid tab. To address projected funding deficits, the state sought and was granted a federal waiver that provides additional federal revenues while placing a five-year cap on the state’s Medicaid expenditures.

In October 2005, Vermont launched its waiver program, called “global commitment to health.” The waiver gives the state greater flexibility to administer and coordinate programs, using a managed-care model. The state will have to keep costs below the capped amount — $4.7 billion in state and federal Medicaid spending (compared to projected costs of $4.2 billion) over the next five years and get to keep any savings.

In return for the cap, the federal government will increase the amount it pays Vermont by 9% annually, using its fiscal 2004 payment as the base year. To better manage program costs, state officials will convert the Medicaid agency into a public managed-care organization.
The additional premiums allow the state to cover more residents with less funding: officials estimate the state will trim the growth in costs and save roughly $300 million over the five years. As noted by Gov. Jim Douglas in his fiscal 2007 budget recommendation, however, the waiver and additional premiums are only a partial solution: The state will need to raise more revenue to fund its share of the plan — $59 million in fiscal 2008, climbing to $267 million in fiscal 2011. And should costs exceed the $4.7 billion, five-year cap, which seems unlikely, the state will have to pay the difference.

**Tennessee: Creating a partnership to share costs and increase coverage**

To help maintain financial discipline and control health care costs in the face of a growing uninsured population, Tennessee has unveiled a new trial program, called CoverTN, to provide affordable coverage for the working poor.

CoverTN is a state-designed and controlled program funded through a voluntary partnership between participants, the state, and employers. Individuals, not an employer, would “own” their coverage, and it would therefore be portable from job to job. CoverTN’s plans to offer premiums of about $150 per month depending on a person’s age, weight, and tobacco use, for benefits that will meet basic needs. One-third of the cost will be contributed by the state, with qualifying employers likely splitting the other two-thirds with employees. The state will retain control over the program, which will feature low deductibles, preventive services, and first dollar coverage.

CoverTN comes on the heels of recent modifications to TennCare, Tennessee’s expanded Medicaid program that started up in 1994. TennCare changes in 2005 preserved full coverage for children, but limited some benefits and reduced enrollment for some adults. The new rules disenrolled about 170,000 non-Medicaid eligible adults from TennCare, brought benefits more in line with other states, and gave TennCare relief from certain consent decrees.

TennCare has reduced program costs by $1.8 billion in the current year and now consumes 26% of the state’s spending, compared with 33% before. TennCare faced a $650 million shortfall in fiscal 2006 before the modifications thanks to unexpectedly high use of clinical services, lack of participation by managed care groups, and the debilitating legal agreements that made it difficult to control expenses. The changes have left TennCare in much better shape, and it remains the seventh most generous Medicaid program in the nation.