

Wisconsin's Hemorrhaging Medicaid Budget: Act 129 Provides a Short-Term Transfusion

(Jon Peacock -- updated April 30, 2004)

A critical issue in the recently concluded legislative session was the deep hole in the Medicaid budget. Late in the session the Governor and legislators were able to agree on a bond refinancing plan that plugs about one third of the potential \$400 million shortfall.

This paper examines the causes of the shortfall, its implications for Medicaid enrollees and the state as a whole, the partial solution that was adopted, and some of the current options for reducing the remaining deficit.

Scorned by that fickle mistress – Rosie Scenario

The biennial budget bill included a number of cost-containment measures to slow the rapid growth in Medicaid-related spending. Some of those, such as the increase in BadgerCare premiums, are having a significant adverse effect on thousands of participants or former program participants. That said, the Governor and Legislature generally did a commendable job of preserving the health care safety net for low-income families, the elderly and people with disabilities.

When elected officials are faced with very difficult choices, they sometimes fall under the spell of an alluring lass known as “Rosie Scenario.” Such was the case in the deliberations on the biennial budget bill last year. To avoid raising taxes or making much deeper cuts in Medicaid-related programs required making some rather optimistic assumptions about state revenue growth and the state’s ability to tap larger amounts of federal Medicaid funding. Unfortunately, Rosie is a rather fickle mistress, and we had to relearn that lesson this year.

The fact that Wisconsin had been jilted by Rosie Scenario was driven home by two Legislative Fiscal Bureau (LFB) memos, the first of which was issued in mid-January 2004. It indicated that the Medicaid budget could have a deficit of as much as \$401 million in state general purpose revenue (GPR). More than three-fourths of that potential shortfall is the result of federal revenue that had been counted on by the budget writers, but which might not be approved. The LFB indicated that as much as \$310.6 million GPR could be needed to replace the federal funding that might not materialize, because the federal government has balked at increasing the amount of intergovernmental transfer (IGT) funds and similar revenue received by Wisconsin.

Using the IGT loophole, the state pays county health care facilities more than the actual cost of health services for Medicaid beneficiaries, receives extra matching funds from the federal government, and then requires the facilities to return the extra funds. Wisconsin received a large and controversial infusion of IGT funding in the 2001-03 biennium, and the state developed a plan to do much the same thing in 2003-05 for community-based county health care programs.

The Governor’s initial budget assumed the state would get \$434 million in increased federal funding from the new intergovernmental transfer (IGT) plan. However, after the plan got a cold reception in Washington, and because Wisconsin received about \$350 million in federal fiscal relief that was part of the economic stimulus legislation, Doyle advised legislators that it would be unwise to anticipate additional federal assistance. He urged them instead to use all of the \$350 million to close the Medicaid deficit.

Legislators did not heed that advice, and their budget bill counted on hundreds of millions from federal IGT revenue.

The “enhanced” IGT funding has not materialized, and it looks increasingly unlikely that it will be forthcoming. The state’s slim chances of getting such funds became even more tenuous in mid-March 2004, when the General Accounting Office issued a report saying it had been inappropriate for the federal Department of Health and Human Services (DHHS) to approve all the IGT funding Wisconsin has already received. That report puts added pressure on DHHS not to approve any pending or new plans to increase IGT revenue for our state.

Escalating Costs

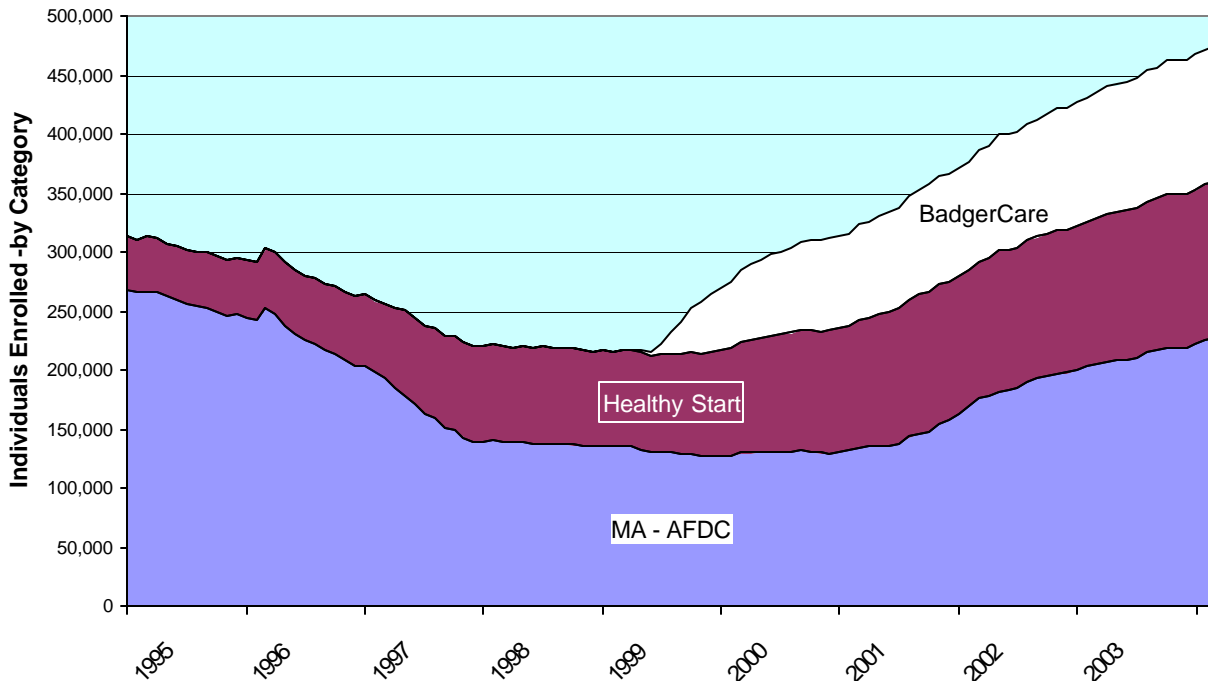
A considerably smaller portion of the Medicaid deficit results from higher-than-anticipated cost increases. The cost side of

the ledger accounts for \$90 million, or 22 percent, of the-potential shortfall.

The cost increases result from at least three different factors. A significant cause is that base spending was higher than expected in 2002-03, which translates into greater spending in the current biennium. A related factor is the fact that spending for prescription drugs has been growing more rapidly than had been anticipated.

The third significant cause of the \$90 million reestimate is caseload growth. The rate of caseload growth seems to be slowing gradually, but it has not slowed as much as the LFB anticipated when the biennial budget was being developed. Fortunately, the growth is in the “family coverage” portion of the Medicaid-related programs, where the cost per enrollee is substantially lower than it is for the elderly and people with disabilities.

**Health Care Enrollment for Low-Income Wisconsin Families
(Jan. 1995 - Mar. 2004)**



The Disappearing Reserve Funds

After the Legislature passed the budget bill and relied on a very large infusion of federal IGT funds, the Governor used his veto pen to increase budget reserves. He cut a small amount of Medicaid funding and moved around some transportation fund dollars in a way that increased reserves to \$186 million. His primary purpose for creating that modest GPR balance was to provide a cushion to address probable shortfalls in Medicaid.

In mid-February the LFB released updated projections of general fund tax collections in the 2003-05 biennium, and we got the second piece of hard evidence that the state had been scorned by Rosie Scenario. The LFB concluded that tax growth would be 4.6 percent in FY 2004 and 4.9 percent in FY 2005, rather than the 5.3 percent and 5.6 percent growth rates that were assumed in the budget bill.

The slower revenue growth means that general fund revenue collections are expected to fall \$222 million short over the biennium, which wipes out the state's modest reserve fund. As a result, the small cushion intended for the Medicaid deficit quickly vanished.

Fiscal and Human Dimensions of the Medicaid Deficit

Although most of the potential \$401 million Medicaid shortfall is federal funding, the IGT funds received by the state are treated like state GPR funding and are reinvested in the Medicaid program to match additional federal funding. That fact helps explain why the LFB classifies the \$401 million as a GPR shortfall. More importantly, it means that the amount of Medicaid cuts that would be needed to close the deficit would be far greater than the GPR figure suggests.

According to the LFB, the \$401 million shortfall would leverage an additional \$561

million in federal Medicaid funds. That brings the total potential shortfall to \$962 million, which represents 25.8% of the Medicaid budget for fiscal year 2004-05.

More than 780,000 people in Wisconsin – one in seven state residents – are served by Medicaid, BadgerCare or SeniorCare. In 2002-03, 77 percent of Medicaid spending was for the elderly and people with disabilities.

The Medicaid-related programs serve nearly 500,000 low-income children and parents – largely in families with at least one working parent. Although they comprise roughly two-thirds of Medicaid enrollment, low-income families account for less than one fourth of Medicaid spending. Thus, even totally ending Medicaid eligibility for everyone but the elderly and people with disabilities would not have eliminated the 25.8 percent shortfall (assuming the reduced coverage took effect on July 1, 2004)!

Economic Impact

Early in 2003, WCCF asked Steven Deller, a UW-Madison professor of Agricultural and Applied Economics, to examine the economic impact of potential cuts to the Medicaid and BadgerCare programs. Using the IMPLAN computer model, Professor Deller analyzed the effect of a 10 percent cut in Medicaid and BadgerCare, which in 2003 would have reduced total expenditures by \$367 million (of which \$148 million was state GPR funding).

Professor Deller's analysis found that a 10 percent cut would cause the loss of:

- 5,700 health care jobs, and 9,100 total jobs.
- \$394 million in wages, salaries and other types of income.
- \$30 million in state and local government revenues, due to lower income, sales and other taxes.

Barring any action to address the Medicaid funding crisis in the current biennium, the potential cuts would have been roughly two and a half times those assumed by Professor Deller for his analysis. Thus, the potential impacts in lost jobs, wages and taxes also would have been about two and one half times those that would result from the hypothetical 10 percent cut that we modeled. Using that assumption, a 25 percent cut in Medicaid spending would result in the loss of more than 22,000 jobs, nearly \$1 billion in lost wages and income, and nearly \$76 million in lost state and local taxes.

Act 129

For more than a month after the Fiscal Bureau announced the Medicaid shortfall, it was unclear whether any action to address the problem would be taken or even proposed. Finally, in late February, the Governor proposed a debt restructuring plan that would free up \$350 million to help fill the hole in the Medicaid budget. The debt restructuring is similar in some respects to debt refinancing, but rather than simply substitute lower cost financing for higher cost bonds, it postpones some of the principal and interest payments. It is the delay in those payments that yields savings in the current biennium.

Key Republicans in the Legislature initially balked at the Governor's proposal. For the record, WCCF supported the restructuring plan, largely because it was the only solution on the table. Nevertheless, we were sympathetic to some of the reservations expressed by legislators. They were right to raise concerns that debt restructuring increases total interest payments over the long haul, and it adds significantly to the structural deficit in the next biennium.

Just a day before the deadline for passage of a restructuring plan that would apply to 2003-04, the Governor and GOP leaders

were able to work out a compromise. That compromise, AB 909, uses debt restructuring just for the first year of the biennium, and not all of the funding is earmarked for Medicaid. The bill generates \$166 million in net savings in this biennium, but it will increase future interest payments by \$46 million, and it increases total debt repayment costs by \$82.5 million in the 2005-07 biennium alone.

The compromise cleared both houses within a day and became Act 129. It uses \$123.5 million to reduce the Medicaid deficit, about \$10 million to fill other budget holes, and \$32.5 million to erase the projected deficit in the budget's closing balance. In other words, except for the probable Medicaid shortfall, Act 129 puts the budget back into balance. However, it still leaves more than two-thirds of the potential Medicaid shortfall unresolved.

The compromise leaves open the possibility that the debt restructuring maneuver could be repeated in the second year of the biennium to free up another \$175 million. However, the prospects for legislative approval of a second round of restructured debt appear remote, since it would come up just as the state begins to grapple with the next biennial budget. Employing a strategy that increases the structural deficit in 2005-07 will become considerably more distasteful as we move into 2005.

Legislative and Administrative Options

Governor Doyle has made it clear that he does not want to close the Medicaid deficit by narrowing eligibility or eliminating benefits. Republican leaders, on the other hand, have not foreclosed those options, though they appear disinclined to want to be perceived as initiating cuts in safety net programs. It is possible that they could call an extraordinary session that would tackle Medicaid and other health care spending,

but that appears unlikely prior to the fall election.

If the full Legislature does not address the remaining deficit, the Doyle Administration has a limited number of options for trying to chip away at it. Their administrative alternatives include:

- Cutting rates for providers.
- Expanding the use of prior authorization for prescription drugs.
- Negotiating larger rebates from prescription drug manufactures.
- Finding new ways to leverage federal Medicaid funds.

The Department of Health and Family Services (DHFS) has been looking at each of those options. One specific possibility that they have been exploring is to start using Community Aids funds for Medicaid. DHFS has developed a proposal to increase the rates for Medicaid-covered services provided by county-based providers (e.g., personal care, outpatient mental health services, Community Support Program services, crisis intervention, and prenatal care coordination), thereby capturing additional federal matching funds. This plan, known as the “county services option,” would be financed by reducing Community Aids payments to the counties and would yield a net gain to the state of \$53.2 million to help support Medicaid. It is designed to maintain the same level of funding for each county, though local administrative costs could increase.

Unlike the other measures listed above, this DHFS proposal requires approval by the full Legislature, and it could potentially be considered during a May special session (which could be concurrent with the Legislature’s veto review period in mid-May, 2004). The plan also requires federal approval. Thanks in part to the fact that it differs significantly from the IGT approach,

the prospects for federal approval now appear fairly good.

One of the budget-cutting options available without approval of the full Legislature is a moratorium or limit on new enrollment in the BadgerCare program. Under the terms of the current federal waivers, people now enrolled in BadgerCare could not be kicked off if the eligibility ceiling were reduced. But those waivers allow the income ceiling to be lowered for new enrollees, and it would be possible to completely freeze BadgerCare enrollment.

An enrollment freeze would mean that parents could not get coverage unless their income is below the AFDC-Medicaid standard, which is \$9,264 for a family of four (49% of the 2004 poverty level). If BadgerCare were eliminated (prospectively or otherwise – by renegotiating the waivers), a single parent who is working full-time for the minimum wage and has four or fewer children would have too much income to be eligible for coverage (though her children would probably be eligible). If she has one or two children and makes \$8 per hour, both the mother and the children would be ineligible (unless the children are under age six).

Maintaining the Health Maintenance Organizations

Even as DHFS considers the possibility of reducing some Medicaid rates, the department may need to increase rates for the health maintenance organizations (HMOs) participating in Medicaid and BadgerCare. The last contracts with the HMOs expired at the end of 2003, though the department exercised a clause renewing those contracts for an additional four months.

Some of the managed care providers have said they are unwilling to sign new contracts without a significant rate increase. This is a

real problem for the department because the HMOs are considerably less expensive than fee for service care. According to recent DHFS figures, the HMOs are receiving \$1,656 per enrollee per year, compared to average annual spending of \$2,800 for fee for service care.

The Doyle Administration tried to set aside money in the biennial budget for HMO rate increases, but the Joint Finance Committee removed that funding, contending that the issue should be addressed after the conclusion of negotiations with the managed care organizations. The Medicaid deficit creates a potential barrier to seeking the committee's approval for increased rates at this time; even though the consequences of not increasing rates might be even more costly.

Conclusion

It was a welcome relief to see legislators and the Doyle Administration put aside their differences to develop a compromise bill that reduces the Medicaid deficit. However, that bill still leaves a funding gap over the remainder of this biennium that could be as much as \$277 million GPR, or \$666 million in combined state and federal funds. It also increases long-term interest expenses and increases the state's structural deficit.

The state can probably chip away at the Medicaid deficit by expanding the use of

prior authorization for prescription drugs, and perhaps also by getting larger rebates from prescription drug manufactures. A plan to use Community Aids funds to boost Medicaid reimbursement rates for certified county-based providers could increase federal matching funds and bring the state a net increase of \$53 million GPR. The Community Aids plan (aka the "county services option") requires state legislative approval, as well as the okay of federal officials in DHSS.

One of the very significant challenges currently facing the state is to keep HMOs in the Medicaid and BadgerCare programs. In light of the state's Medicaid deficit, providing an adequate rate increase for the HMOs could be extremely difficult. In the short run, it might be easier politically simply to freeze those rates. Over the longer haul, however, the loss of HMO participation would drive up costs and create even larger Medicaid and BadgerCare funding challenges.

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