

Show Me Series: Report 7
Profiles of Medicaid Reform
A Look at Other States



The Missouri Foundation for Health (MFH) was created in January 2000 as part of a negotiated agreement among Blue Cross/Blue Shield of Missouri (BCBSM), the Missouri Department of Insurance and the Missouri Attorney General following the for-profit conversion of BCBSM. The Foundation received a significant portion of the assets of RightChoice, the for-profit created by the conversion. MFH is dedicated to improving the health of the people in the BCBSM service area, which encompasses 84 Missouri counties and the City of St. Louis.

In support of its mission, MFH undertakes policy studies on topics of significance to the Foundation service area and beyond. MFH has created the Show Me Series and other publications to convey information about current health related issues of interest to a broad audience ranging from members of the general public to policymakers.

Show Me Series: Report 7

Profiles of Medicaid Reform

A Look at Other States

This Missouri Foundation for Health (MFH) paper profiles five states (Florida, Maine, Massachusetts, Oregon, and Tennessee) for the purpose of examining recent changes implemented in their Medicaid programs. The discussion includes consideration of the various Medicaid cost-containment measures used by these states, as well as the effect the changes have had both in terms of cost savings and human impact. As the Missouri Medicaid Reform Commission works to improve Missouri's Medicaid program, it is essential for both policymakers and the public to clearly understand the economic and social impact of any potential changes being considered for Missouri's program.

Policy decisions concerning public revenues and expenditures have a substantial effect on both the health care system and individual health outcomes. Missouri, like the rest of the nation, was negatively affected by the recession that began in 2001¹ and has struggled to balance its budget each year since. Throughout this period of economic stress, health care costs have far outpaced the general economic growth of the nation. This fiscal strain has been acutely felt by states in regard to Medicaid programs. At the same time, it is precisely during these strained economic

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times when low-income individuals and families are most in need of support through programs such as Medicaid.

The sky-rocketing health care costs have also taken a toll on employer-sponsored health insurance, as many businesses are forced to shift costs to their employees or eliminate health insurance benefits altogether. If not for Medicaid, the number of uninsured Missourians would have grown even higher during the recent recession.

In the last three years, all 50 states have implemented some Medicaid cost-containment measures. After slowly expanding Missouri's Medicaid program over the course of several years, Missouri cut eligibility for the elderly, the disabled and the parents of minor children in the 2005 legislative session. Additionally, Missouri eliminated its Medical Assistance for the Working Disabled and its General Relief programs. Increased premiums were also implemented for approximately 46,000 children in families with incomes between 150 and 300 percent of the federal poverty level (FPL) [See Appendix A] who are covered by Missouri's State Children's Health Insurance Program (SCHIP). As reform efforts continue in Missouri, policymakers will be faced with carefully balancing the need to control Medicaid costs and the needs of the state's most vulnerable citizens, many of whom, without Medicaid, will lack the means to afford basic health care.

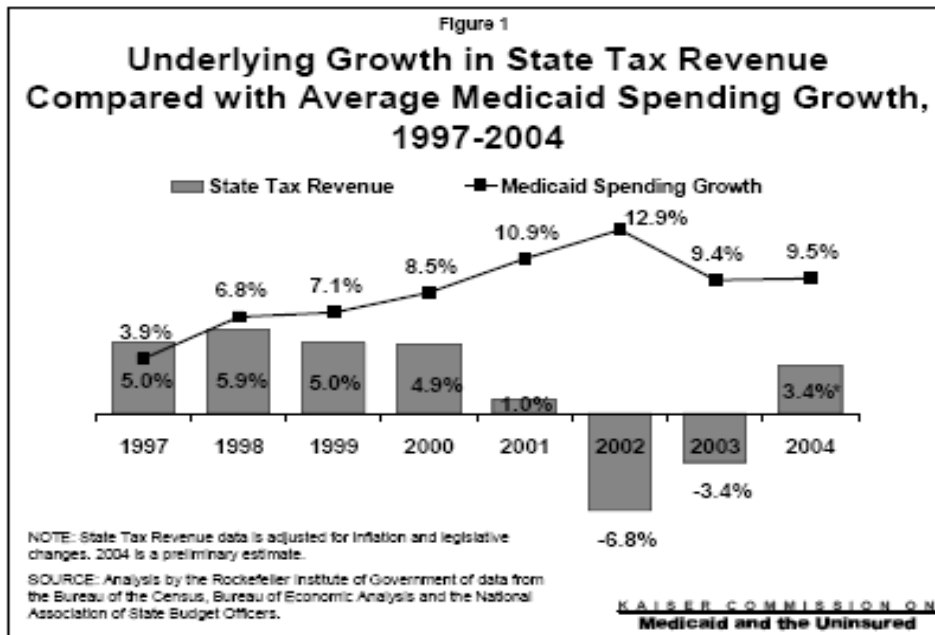
State Challenges to Financing Medicaid

Projected federal and state spending on Medicaid will reach \$329 billion in 2005.² Covering more than 53 million Americans, Medicaid has become the nation's largest health insurance program. At the same time that Medicaid has been growing at dramatic rates, both in terms of enrollment and cost, the states have faced large revenue declines due to the downturn in the economy. In all states, except Vermont, legislatures are required to maintain a balanced budget,¹ and in each of the last four years the states have faced billion dollar shortfalls:

- \$40 billion in fiscal year (FY) 2005,
- \$80 billion in FY 2004,
- \$75 billion in FY 2003, and
- \$40 billion in FY 2002.³

These deficits largely reflect diminished performance of the economy resulting in the significant loss of state revenues. The decline in the stock market coupled with job losses led to reduced revenues from both income and capital gains taxes. Additionally, the recession decreased sales tax revenues, which account for more than 30 percent of all state tax revenues.⁴

Even as the economy begins to recover, Medicaid expenditure growth has expanded faster than overall inflation and state revenue growth. In general, Medicaid expenditures are tied to the medical market where annual cost increases have consistently surpassed growth in wages and general price inflation. Average state revenues increased by only one percent in 2001 and decreased by 6.8 percent in 2002, while during those same years Medicaid spending growth averaged around 12 percent per year. In 2003 state revenue growth dropped an additional 3.4 percent and began a slight recovery in 2004, with average state revenue growing 3.4 percent. However, Medicaid spending growth increased 9.5 percent in 2003 and again in 2004.⁵



Factors Contributing to Medicaid Spending Growth

From 2001 to 2005, Medicaid spending across the nation has increased by over 50 percent.² This substantial rise in spending was driven by three main factors: Medicaid eligibility growth, expanding prescription drug costs, and escalating costs of medical

services.⁶ Other factors involved in increased Medicaid expenditures include long-term care costs, growth in waiver populations and services, and transportation costs.

Nationally, Medicaid enrollment grew by 40 percent over the last five years.² This large jump can partially be explained by the counter-cyclical manner in which Medicaid responds to downturns in the economy. This means that when the country experiences a recession, as in recent years, that the Medicaid program acts as a safety net to provide health care for certain eligible people. Yet, this alone does not entirely explain the large increase in enrollment.

Another factor that has triggered Medicaid eligibility growth is the escalating health care costs in the United States. Health care costs have been rising at a rate far above overall economic growth for several years. This in turn affects both private insurance and governmental programs. In 2005, average private health insurance premium increases ranged from 8 to 10 percent, down from an average 12 percent increase in 2004. In turn, employers increased deductibles and copayments or discontinued benefits altogether for the fourth year in a row.⁷ These cost increases have made employer-sponsored health insurance a less affordable option for both the employers and employees. Newly released census data shows a continued decrease in the percentage of people covered by employment-based insurance, from 61.3 percent in 2002 to 59.8 percent in 2004.⁸ Taking into account the recent recession and the rapid rise of medical costs, the increase in the number of people enrolled in Medicaid begins to make more sense.

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Finally, the Medicaid program is also sensitive to increases in health care costs. Medical cost growth rates have decreased from a high of 11.3 percent in 2001, but even the 2004 growth rate of 8.2 percent remains above the general economic growth rate of 5.6 percent.⁷ Much of this escalation in health care costs can be traced to increased spending on prescription drugs, outpatient hospital care, and physician care.² Increases in Medicaid expenditures follow the national growth in medical costs that have been occurring over the last five years.

Why Medicaid Matters

Individuals and families enrolled in Medicaid, who are more often poorer and sicker than the privately insured, depend on this health insurance program for preventive, medical, and long-term care services.⁹ A recent study showed that the majority (over 65%) of people who lose Medicaid coverage become uninsured. The other individuals that lose coverage either buy into employer sponsored insurance (28%), become eligible for Medicare (4%), or purchase individual health plans (2%).¹⁰ Those who become uninsured are more likely to face decreased access to health care; minimal preventive care; and a higher rate of emergency room use, which puts families at a greater risk for substantial medical debt.¹⁰ During the recent recession, Medicaid was a major factor in limiting the growth in the number of uninsured because it was available to families who lost health insurance when they lost their jobs, or when an employer or employee dropped health insurance benefits because of affordability issues.² If Medicaid expenditures are reduced through a cutback in eligibility, the health care needs of the newly uninsured individuals and families do not disappear. The costs simply shift to other parts of the health care system and to other parts of the state budget. Many of these costs show up on the ledgers of providers as uncompensated care which in turn forces up the cost of private health insurance.¹ A June 2005 report by Families USA found that “health insurance premiums for families who have insurance through their private employers, on average, are \$922 higher due to the cost of health care for the uninsured that is not paid for by the uninsured themselves or by other sources of reimbursement.”¹¹

Medicaid also fills the gaps for dual eligibles (those eligible for Medicaid and Medicare) by paying their Medicare premiums, coinsurance, and deductibles. Approximately 42 percent of all Medicaid expenditures are currently for individuals who also have Medicare coverage. Medicaid essentially underwrites Medicare by paying for services such as nursing home care and prescription drugs.²

Finally, Medicaid sets an example for restraining per capita growth in spending compared to private insurance companies. Medicaid per capita growth in the cost of acute care was just 6.9 percent from 2000 to 2003, compared with 9.0 percent for all Americans with private insurance coverage and 12.6 percent in employer-sponsored

health insurance. Medicaid has achieved this impressive performance by having administrative costs on average between 4 and 6 percent (Missouri's Medicaid program had administrative costs of 4.4 percent in 2003). In contrast, both a health maintenance organization (HMO) with 8 to 12 percent administrative costs, and a commercial health insurer with 15 to 20 percent

Medicaid sets an example for restraining per capita growth in spending compared to private insurance companies.

administrative costs would be regarded as efficient within their respective markets.² No other health insurance program has performed better than Medicaid at controlling health care spending, and no health insurance program has lower administrative costs.²

STATE EFFORTS TO REFORM MEDICAID

The following sections profile other states efforts to find a balance between budgetary stringency and maintaining health insurance through Medicaid for the neediest and most vulnerable people. All states, to varying degrees, have faced budget pressures during the last four years. They have been forced to make complicated choices between spending cutbacks, tax increases, or other revenue measures. As one of the fastest growing portions of most state budgets, the Medicaid program has been the focus of cost-containment efforts in every state in the nation. Nonetheless, many states have managed to extend their health care dollars through innovative strategies to increase health care access, coverage, and efficiency through sound financial management.

The experiences of states in their efforts to reform Medicaid differ greatly. However, a state may greatly benefit by drawing from the collective knowledge-base of other states. Examining other states provides Missouri with a range of ideas and options as it faces the challenges of reforming its Medicaid program.

Oregon

Oregon was one of the very first states to obtain a federal waiver under Section 1115 of the Social Security Act (now known as an 1115 waiver) for its Medicaid program. This waiver created the Oregon Health Plan (OHP) which expanded coverage up to 100 percent of the federal poverty level (FPL) for families and childless adults. At the same time, the waiver worked to control costs by utilizing a managed care delivery system and

a prioritized list of services. Enrollment for the expansion groups began in 1994, and Oregon's rate of uninsured decreased from 18 percent to 10 percent between 1994 and 1998.¹²

Budget shortfalls prompted Oregon to apply for another waiver through the Health Insurance Flexibility and Accountability (HIFA) Act (known as a HIFA waiver) which created the Oregon Health Plan 2 (OHP2) that was implemented in early 2003. This amendment to the original OHP formed subdivisions within the health plan (OHP Standard and OHP Plus). The OHP Plus subgroup preserved the original OHP benefit package for children and mandatory Medicaid populations. The OHP Standard subgroup generated a health plan with reduced benefits, premium increases, and new copayments for those who had qualified under the "expanded eligibility" of Oregon's original Section 1115 waiver. OHP Standard's premiums and copayments were based on a sliding scale; however, the new waiver eliminated premium exemptions even for those with zero income. The scaled back benefit package for Medicaid recipients included the elimination of coverage for outpatient mental health and substance abuse services, durable medical equipment, dental, and vision. Finally, Oregon implemented strict administrative policies that ordered a six-month lockout for missing a premium payment.^{12, 13}

By reducing the benefit package for OHP Standard enrollees, the Oregon HIFA waiver was able to extend coverage for children and pregnant women up to 185 percent of the FPL. OHP2 also planned for an expansion of coverage for adults (parents and childless) with incomes between 100 percent and 185 percent FPL; however, due to budget constraints this expansion never materialized.¹⁴

In mid-2004, several more major changes occurred to the OHP2 program. First, drawing on a new revenue source from a provider tax, the legislature reinstated mental health and substance abuse benefits. Also, as a result of litigation, copayments for the OHP Standard subgroup were eliminated. However, as of July 1, 2004, Oregon closed enrollment for the OHP Standard waiver program and expected its rolls to drop to near 25,000, down from 100,000 enrollees in 2002.^{6, 12}

A report by The Commonwealth Fund released in July 2005 studied the impact of the OHP2 program changes, and found that within 18 months of the changes 67 percent of OHP Standard enrollees had lost their Medicaid coverage. Adults covered under OHP Standard had incomes less than 100 percent FPL. Many of these individuals could just not afford the premiums and copayments associated with the new OHP Standard program. Of those that lost coverage, nearly 75 percent became uninsured. Those who lost coverage had:

- reduced access to care,
- less primary care utilization,
- gone without or delayed necessary care,
- faced greater financial hardships than those who remained enrolled in OHP, and
- experienced a decline in health status.^{12, 15}

These losses in coverage and problems affording premiums and copayments led to greater pressures on both providers and the health care safety net. Due to loss of Medicaid coverage for a large number of individuals, Oregon experienced increased emergency room use by the uninsured and large jumps in demand at the Federally Qualified Health Clinics (FQHCs).¹⁶ On top of increased demand, the FQHC's struggled financially because they rely on Medicaid for a large part of their funding. According to a study by the Kaiser Family Foundation, states such as Oregon may be deriving their overall savings from reduced enrollment and utilization, rather than from increases in revenue from new premiums and copayments.¹⁶

Conversely, Oregon also offers positive examples of cost-containment methods for their Medicaid program. Through legislation, the state asked the Center for Evidence-Based Policy at the Oregon Health and Science University (OHSU) to establish effectiveness comparisons between drugs in the same class in order to create a preferred-drug list. The Drug Effectiveness Review Project (DERP) "provides states and other purchasers with information on the relative effectiveness of similar pharmaceuticals in 25 drug classes and consultation in applying that evidence to purchasing and management decisions."¹⁷ The DERP program is based on the idea that purchasing pharmaceuticals using evidence-based information will create long-term efficiencies, more appropriate pharmaceutical utilization, and improved health outcomes. As of July 2004, 11 states, including Missouri, had signed contracts to participate in the project. Other studies have

evaluated individual pharmaceuticals, but this project is the first to conduct comparative systematic reviews of all drugs within their respective therapeutic classes.¹⁷

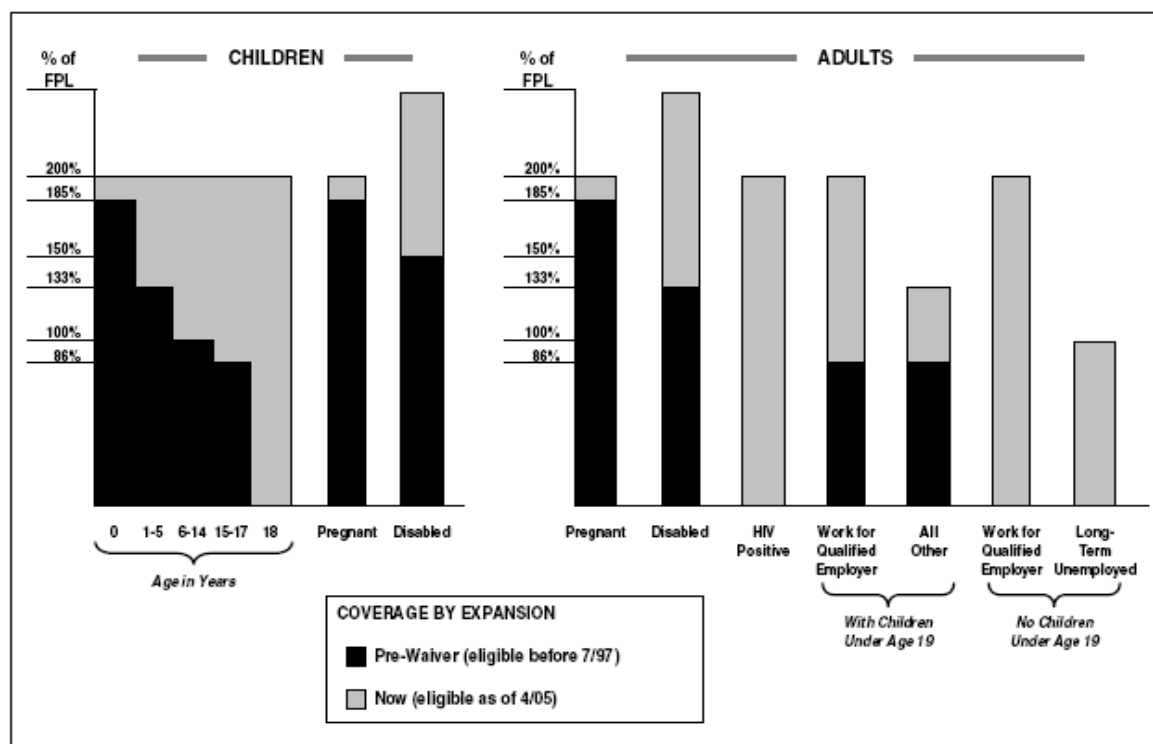
Since 1997, Oregon has run the Family Health Insurance Assistance Program (FHIAP) which subsidizes premiums paid by qualified uninsured people with family incomes less than 185 percent FPL. Insurance coverage can be employer-sponsored, individual insurance, or coverage in the state's high risk pool (Oregon Medical Insurance Pool). FHIAP pays 50 to 95 percent of the premium depending on income and family size. As part of Oregon's HIFA waiver, the state can now draw down federal matching funds for FHIAP. As of August 2005 approximately 13,400 people who otherwise would not be able to afford health insurance had coverage through this program.^{15, 18}

Oregon's attempts to redesign the OHP program offer lessons and insight into cost-containment measures for Medicaid programs around the nation. Often, changes that seem reasonable and cost-effective may have unforeseen social and economic impacts on people's lives. A 2005 study of Oregon's changes to Medicaid found that many individuals accumulated significant personal debt when they lost health coverage. In addition, those who retained coverage but faced higher premiums and copayments reported trade offs to afford the cost shares, such as getting behind on rent or skipping meals to save money. Both those who lost coverage and those facing higher cost-sharing often reported higher levels of stress and were more likely to report episodes of depression.^{12, 15, 16} States must weigh all factors as they move forward in their attempts to balance state budgets while still protecting some of their neediest and most vulnerable citizens.

Massachusetts

In 1997, Massachusetts implemented a comprehensive Medicaid-SCHIP expansion referred to as MassHealth through a section 1115 waiver. While the program has many different components and funding sources, MassHealth appears seamless to the beneficiaries of the program. MassHealth expanded Medicaid coverage in all of its categories, usually up to 200 FPL, and even higher for children and adults with disabilities (higher income individuals with disabilities can enroll in MassHealth by paying a sliding-scale premium).¹⁹

Overview of MassHealth Waiver Eligibility Changes



Source: Massachusetts Medicaid Policy Institute, *The Mass Health Waiver*, April 2005, http://www.massmedicaid.org/pdfs/MassHealth_Waiver.pdf, p. 3.

Massachusetts also has the Family Assistance Premium Assistance (FAPA) and Insurance Partnership (IP) programs which encourage employer-based insurance by offering subsidies to low-wage workers, small businesses, and low-income self-employed individuals. The FAPA program focuses on providing subsidies to employees of firms that offer insurance for which the low-income employee cannot afford their share of the premium. Massachusetts employers must cover at least 50 percent of the costs and the insurance benefits must meet a state specified basic benefit level. The IP program focuses on employers by encouraging small business owners with low-income employees to begin or continue to offer health insurance benefits. These programs receive financing through a combination of Medicaid and SCHIP funds and as of mid-year 2004 the programs assisted with health insurance coverage to over 22,000 individuals.²⁰

Since 1997 Massachusetts has operated an Uncompensated Care Pool which reimburses community health clinics and hospitals that offer health care to eligible low-income uninsured individuals. During the recent recession funding for the pool has often

been tight and has required many revisions in its financing structure. Funding comes from a variety of sources, including assessments on hospitals and insurers, intergovernmental transfers, state funds, federal matching Disproportionate Share Hospital (DSH) funds, and tobacco settlement dollars. DSH payments are additional funds given to hospitals to finance care to low-income and uninsured patients. Recent reforms to the pool have focused on cost savings, which include prospective reimbursement (pre-set payments for specific diagnoses) and one application both for the pool and MassHealth (this allows the state to screen and enroll eligible people into Medicaid, thereby reducing the number of people for whom the pool subsidizes care).²¹

The pool has also funded 12 demonstration projects to test techniques for improving access, care, and health outcomes. The projects also have studied how to decrease costs for uninsured individuals with chronic conditions. Results have repeatedly shown that case management, emphasis on primary care, patient/family education, and other interventions for high-risk patients have improved care and health outcomes.²¹

Massachusetts felt the effects of the 2001 recession in the form of a \$2 billion budget gap in 2003 and a \$3 billion shortfall in 2004. While the state implemented some cost-containment methods and restructured the MassHealth program, the Massachusetts Medicaid program had broad support from many policymakers and the general public. Preserving the MassHealth program was a top priority even during a time of economic stress and increasing medical costs. Some of the shortfall during these years was made up through revenue increases. Massachusetts raised fees, closed corporate tax loopholes, tightened audits, delayed an income tax cut, and implemented some one-time shifts (such as paying pension-fund obligations by property transfer rather than cash) as ways of increasing state revenues during these lean economic years.²²

However, revenue increases alone did not cover the entire shortfall and cost-containment action was needed. The state imposed spending cuts for higher education, public health, and local aid. In addition, the state enacted a range of measures to control costs within the MassHealth program over the past several years. These included:

- Reductions in payments to providers including hospitals, nursing homes, physicians, pharmacists, and managed care organizations;

- Cutting certain optional services including prosthetics, orthotics, and eyeglasses (some of these services were subsequently restored);
- Creating MassHealth Essential, which moved 36,000 long-term unemployed individuals to a program with somewhat lower eligibility and health care benefits than its predecessor (it also has a spending ceiling and permitted a waiting list if needed);
- Small increases in beneficiary premiums and copays for higher eligibility groups;
- Imposing caps on enrollment in a few MassHealth programs (to date no waiting lists for these programs exist due to the establishment of a very high cap);
- Narrowing the disability determination standard and process;
- Cutting, than a year later restoring, eligibility for individuals with HIV from 200 percent FPL to 133 percent FPL; and
- Increasing generic substitution requirements and imposing prior authorization for seven or more prescriptions per month.^{14, 22, 23}

As the state revenue picture began to improve for Massachusetts, some of the pressures on Medicaid and other state programs decreased. Although MassHealth experienced some restructuring and cuts during the last few years, it was mostly protected due to health insurance being a top priority for policymakers and the residents of the state. For 2006 Medicaid spending in Massachusetts is expected to only grow at a rate of 5.6 percent. Additionally, both Governor Mitt Romney and legislative leaders have announced that they want to make progress toward universal health coverage in 2006. Although neither of these groups has released concrete proposals, the Blue Cross Blue Shield of Massachusetts Foundation has partnered with the Urban Institute in the creation of its Roadmap to Coverage initiative. This project aims to further the public debate on providing health coverage for everyone in Massachusetts and will offer policy choices that include an analysis of the effects on costs and coverage for each option considered.²² It should be noted that the Missouri Foundation for Health has contracted with the Urban Institute to do preliminary work for a similar analysis in Missouri.

Tennessee

In 1994 TennCare replaced Tennessee's Medicaid program through an 1115 waiver that moved all Medicaid recipients into managed care and expanded coverage to previously uninsured persons. TennCare coverage became available to traditional Medicaid eligibles, the medically uninsurable, and uninsured persons not eligible for employer-based coverage or a publicly-sponsored health program. The concept was that the amount of funds produced by switching to a managed care system and by transferring federal and state payments (that had been going directly to hospitals for indigent or uninsured care) to TennCare would be enough to pay for insurance coverage to the expanded TennCare population.²⁴

From the beginning TennCare was plagued with problems due to underfunding and a disproportionate share of high-risk patients. Enrollment in TennCare was 50 percent higher than the state Medicaid program prior to the 1994 waiver. This remarkable increase in enrollment sharply reduced the number of uninsured in Tennessee for several years. However, due to budget constraints the state has slowly scaled back TennCare eligibility and has closed enrollment for some groups that were covered in the original waiver. These decreases in TennCare coverage, combined with the downturn in the economy, have contributed to a slow rise in the number of uninsured in Tennessee.^{24, 25}

A modified 1115 waiver was submitted in 2002 to the federal government that restructured and constricted the TennCare program. A new TennCare Standard coverage category was created that had reduced benefits and increased premiums and copayments for some of the higher income existing beneficiaries. The waiver also discontinued the Early and Periodic Screening, Diagnostic, and Treatment benefit for some children for whom such coverage was optional. However, as a part of a court settlement Tennessee abandoned several of the changes from the 2002 waiver and submitted a new 1115 waiver proposal in September of 2004.^{14, 25}

In 2004-2005 Tennessee was on the forefront of the Medicaid debate around the nation as legislators, Governor Phil Bredesen, advocates, the media, beneficiaries, and the general public debated changes to the TennCare program. As written, the 2004 waiver outlined several major changes to the TennCare program, including:

- a new standard for determining whether an item or service is “medically necessary”²⁶ (This standard would be more restrictive than standards used by any other state or commercial insurance carrier. Under this standard, in order to be paid for, an item or service covered by Medicaid must meet a number of criteria, including a requirement that the item or service be the “least costly” alternative course of diagnosis or treatment for which there is adequate “clinical scientific evidence” of its safety and effectiveness.);
- broad authority to make changes to the TennCare program that would be necessary to meet a new state spending target (in order to meet a total amount of state tax revenues spent on TennCare each year, the waiver asks for authority to make necessary eligibility, benefit, and cost-sharing changes without further review by the federal Centers for Medicare and Medicaid Services (CMS));
- a new tiered pharmacy formulary and the creation of three groups of drugs in which access would be restricted for two of the three groups of drugs; and
- specified eligibility, benefit, premium, and cost-sharing changes.²⁵

This 2004 waiver left mandatory eligibles, as well as some other groups, in the TennCare Medicaid program; while moving additional enrollees to TennCare Standard. The waiver created additional limits in benefits, premium increases, new copayments, and limits on appeal rights for some TennCare Standard enrollees.²⁵

Debate over this waiver stalled its progress and in November 2004. The governor asked CMS to table the waiver and announced that he was considering a process to dissolve TennCare and replace it with a traditional Medicaid program (focused on mandatory populations of eligibles) unless talks between the state and advocates for TennCare beneficiaries resulted in an agreement about program reforms. Although ultimately TennCare was not eliminated, the governor’s announcement made it clear that the state was facing a serious fiscal crisis and drastic steps needed to be implemented to keep the TennCare program running.²⁷

Updates to the changes in the TennCare program occur on a daily basis and everything will not be “sorted out” in terms of “who is eligible” and “under which program” until well into 2006. Nonetheless, in 2005 Tennessee began to implement major changes to the TennCare program and is finalizing other changes which still must be approved by CMS.

First, approximately 200,000 TennCare adults have begun to be eliminated from the TennCare program. None of the 612,000 children in TennCare will lose coverage or be subject to coverage changes. The governor's revised plan also would create a basic TennCare program which would have limited benefits, including coverage for only four prescriptions per month, 12 physician visits per year, and 20 days of hospital care annually. Originally, about 100,000 "medically needy" adults, who have incomes too high for traditional Medicaid but cannot afford their medical bills, were on the list to lose coverage. However, beneficiaries and their advocates worked with the state to craft a settlement that maintained coverage for these individuals. In return, the state received court approval of changes to a 1999 consent decree that allows it more flexibility, pending CMS approval, over TennCare benefits as outlined above. Furthermore, the "medically necessary" definition would change as outlined in the 2004 waiver and appeals hearings for enrollees losing coverage will be limited.^{28, 29}

Tennessee has offered some assistance in easing the transition for TennCare adults being dropped from the program. The state has established an \$11.4 million agreement with community mental health agencies to continue providing services to 20,000 beneficiaries with severe mental illnesses. Additionally, most of the individuals losing TennCare coverage will receive temporary access to free or low-cost prescription drugs under a \$57 million state program that contracts with Missouri-based Express Scripts to provide those who are losing coverage with free or low-cost generic drugs.³⁰

At its peak, the TennCare program covered 1.3 million Tennesseans or 26 percent of the state's population. Tennessee's Medicaid program was the most generous in the nation. Yet, fiscal crises and budget constraints have led to scaled back coverage and according to the governor have placed the state in the unfortunate position of making major cuts in eligibility and reducing benefits. Other state officials and advocates claim that there are better ways to contain costs, including implementing disease management programs, joining a multi-state purchasing pool for prescription drugs, and the use of a retroactive drug use review program. These options allow TennCare enrollees to retain their coverage, which keeps the uninsured rate from increasing. Recent studies validate this choice by documenting that both short and long periods of uninsurance decrease access to care, increase the risk of catastrophic medical bills, and lower the rate of preventive care.¹⁰ Tennessee's recent experiences illustrate the dilemma of budget

constraints versus the impact that eligibility cuts can have on the rate of uninsured and individual's access to quality health services.

Florida

Reflecting the national trend, Florida's Medicaid program experienced decreases in enrollment between 1995 and 1998 despite a moderate increase in expenditures for the program. However, this trend began to reverse in the late 1990s and enrollment has greatly increased in the last five years. Much of the increase in the late 1990s can be attributed to enrollment in Florida's newly established State Children's Health Insurance Program (SCHIP). Acute care spending per enrollee was comparable to other states, but long-term care spending per enrollee was well below the national average. One area that ran counter to this trend was prescription drug expenditures in Florida's Medicaid program, which had a significantly higher growth rate compared to the rest of the nation from 1995 to 1998 (18.7 percent for Florida versus 11.2 percent for the nation). Despite growing enrollment and increasing expenditures, Florida continued to expand its Medicaid program in the 2001 legislative session. Florida expanded eligibility for uninsured women diagnosed with breast and cervical cancer and authorized the creation of an insurance premium subsidy program for privately insured Medicaid-eligible persons.³¹

Disease Management Cost-Containment Efforts

Since 1999, Florida has provided disease-management (DM) services to individuals enrolled in MediPass, the Medicaid managed-care program that utilizes a primary care case-management mechanism. The DM programs target MediPass patients with conditions such as HIV, diabetes, cancer, and congestive heart failure. The state contracts with eight DM organizations to address each high-cost illness.

While DM provides some cost savings in the short-run, its greatest benefit may be by the improvement of care by providers and administrators, which in turn has lasting effects on health outcomes.

Source: Silow-Carroll, Sharon and Tanya Alteras, "Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness," The Commonwealth Fund, 2004.

Although Florida's revenues have recovered faster than other states, the recession hit Florida hard with a \$1 billion shortfall in 2002. Additionally, Medicaid and SCHIP spending increased 18.1 percent that year, producing significant strain on the state's budget. Before the recession, Florida had focused most of its cost-containment efforts on Medicaid pharmaceutical spending. In 2000, the state limited the number of brand-name prescription drugs that Medicaid recipients could receive per month without prior authorization, reduced the reimbursement levels for pharmacies that dispense drugs to Medicaid patients, and required generic drug manufacturers to offer the state a rebate. In the following two years, the legislature created a drug benefit management program and a Medicaid preferred drug list program, which allows the state to directly negotiate rebates with drug manufacturers in exchange for placing the manufacturers' drugs on the state's preferred drug list. These state-negotiated rebates supplement the manufacturer rebates already provided to states under federal law.³¹

While the Florida legislature had previously avoided cuts to eligibility for several years in a row, in 2002 the budget crisis caused by increasing costs and decreasing revenues led to several eligibility changes in the state's Medicaid program. The eligibility threshold for the state's elderly and disabled Medicaid enrollees was reduced from 90 percent FPL to 88 percent FPL; and Medicaid coverage of dental, visual, and hearing services for adults was restricted or eliminated (since that time some dental services have been reinstated).³¹ In 2003, cost savings in Medicaid were achieved through a cut in nursing home rates, the institution of a 2.5 percent coinsurance payment for some pharmaceuticals, expansion of a nursing home diversion program, and the implementation of a \$15 copay for non-emergency use of hospital emergency rooms.³²

One of the most contentious actions taken by the Florida legislature was the capping of enrollment in the state's SCHIP program, Healthy Kids, in 2003. Enrollment in the program was capped by limiting the amount appropriated in the state budget to cover Healthy Kids expenditures. This budgetary limit creates a maximum number of children that can be covered using the set amount of funds. Eligible children who exceeded that number would be placed on a waiting list. In addition, outreach efforts to enroll children were eliminated, a waiting list was established, a cap was placed on annual child dental benefits, and monthly premiums for the Healthy Kids program were raised. By November 2003, the Healthy Kids waiting list exceeded 44,000.³²

At its maximum, the waiting list to enroll in Florida's SCHIP program reached 90,000. In the spring of 2004, the legislature disbanded the waiting list and allocated state funds to enroll the SCHIP-eligible children who were on the waiting list as of March 11, 2004. Then, instead of a waiting list, they created the option (not a requirement) of having two months of open enrollment (September and January) where parents could enroll their children in Healthy Kids. Furthermore, the legislature instituted more rigorous verification requirements which may compromise a family's ability to understand and comply with all the procedures necessary to enroll their children.³³ Finally, in June 2005 Governor Jeb Bush signed legislation which allows low-income families to apply to KidCare (name changed from Healthy Kids) throughout the entire year. The cap in enrollment is set at 389,000 children, but as of June 2005 only 239,000 children were enrolled in the program.^{34, 35}

Most recently, the governor of Florida proposed a major plan to reform the state's Medicaid program through the use of an 1115 waiver. The reform plan passed the state legislature in the spring of 2005 with some changes as recommended by beneficiaries, advocates, providers, community leaders and state officials. The full waiver was released for public comment on August 30, 2005, and will be submitted to CMS for approval on September 30, 2005. Currently, the plan calls for a pilot of the waiver program in two Florida counties in the spring of 2006, and if successful further expansions will occur to three additional counties within a year.^{36, 37, 38}

This waiver will reinvent Florida's Medicaid program to look and operate more like a private health care market. The reform plan does not change current eligibility categories or income and asset limits. The reform plan will eliminate the fee-for-service system used for Medicaid in parts of Florida and will create a managed care system for all Medicaid beneficiaries. Enrollees will have a choice of health plans, which will offer equal but customized benefit packages. Independent choice counselors will help enrollees choose a plan that meets their actual needs. Cost sharing may differ by plans, but can not exceed the current amounts. Medicaid recipients will also be allowed to opt-out of Medicaid and use their state-allocated Medicaid premium to participate in an employer-sponsored plan. Finally, participants in a Medicaid reform plan can earn "credits" by participating in wellness activities such as screenings, immunizations, well

child exams, smoking cessation programs, weight loss programs, etc. These credits can then be used to pay for health related expenses not usually covered by the health plan, including copayments, over-the-counter medications, or eyeglasses.^{38, 39}

The Florida reform model will work in a manner similar to a consumer-directed health plan. The state will pay a monthly premium to participating health plans that will provide Medicaid enrollees with a defined set of benefits and services. Individuals who undergo health care services costing more than a specific threshold amount in one year would be re-insured by either the state or the health plan up to a maximum benefit limit. This catastrophic premium component covers the bulk of an individual's medical expenses, minus any required cost sharing, after the individual's medical expenses exceed a pre-established catastrophic threshold. The state will establish criteria that offer some health plans a financial choice for managing high cost cases – accept the premium and self-insure, or reject the premium and have the state act as re-insurer. The transition over this “threshold” will be defined by a dollar amount and should appear seamless to the recipient. On the budgetary side of the reform plan, the state believes that by using a managed care approach that they can better predict Medicaid costs, control expenditure growth, and set a global cap with a set rate of growth per year.^{39, 40}

The success or failure of the Florida plan cannot be predicted. However, there are risks that should be kept in mind as the state moves forward with Medicaid reform. The amount of cost savings may not be as high as expected because 61 percent of current Florida Medicaid recipients already participate in a managed care program. Additionally, the rate of growth in health care costs remains very hard to predict and the state has some risk of painting itself into a corner if spending exceeds budgeted growth rate amounts. Florida's plan sets fixed premium amounts for different populations to be paid to the participating health plans. These premiums will be set according to historical Medicaid expenditures for mandatory and optional services. Having set premiums for all Medicaid enrollees may change the fiscal incentives that encourage states to maintain investments in coverage (i.e., not reduce eligibility because of budget constraints) or make other improvements in their Medicaid programs such as increasing provider reimbursements over time. Finally, it will be important to track whether this type of health care plan meets the needs of populations that are unique to Medicaid, e.g., low-income elderly and disabled or those with chronic illnesses. This model attempts to balance

individual health care needs with the pressures of maintaining a balanced state budget. Tracking and evaluation of Florida's efforts at reform will be necessary to determine its success.⁴¹

Maine

In June 2003, in the midst of the national recession, a new Maine law created a two-part universal health care plan to be phased in through 2009. This plan, called Dirigo Health, aims to achieve three major goals: 1) ensure access to affordable coverage for the uninsured and underinsured; 2) slow down the growth of health care costs; and 3) improve quality of care. The state hopes to cover an additional 190,000 individuals over the course of five years which would essentially create a universal coverage in the state.²⁰

The Dirigo Health package introduces a public-private insurance program that provides low-cost health insurance for the self-employed and for small business employees. Under Dirigo Health, the state will contract with private insurance carriers to offer coverage to employees who work at least 20 hours per week. The employers would be responsible for up to 60 percent of the insurance premiums, and the employees would cover the remainder. In addition, premium subsidies for employees would be available for those with incomes less than 300 percent FPL. Employers would also be offered subsidies to encourage participation in the plan. The second part of the health care package expands coverage in the state's Medicaid program (MaineCare) to 125 percent FPL for childless adults and to 200 percent FPL for adults with children.⁴² Implementation of the Dirigo Health plan began in January 2005 with additional components scheduled for implementation throughout 2005 and into 2006.

The entire plan will be paid for through:

- new fees on insurers' gross revenues,
- \$53 million in one-time federal funding for use in year one of Dirigo,
- employer and employee premiums,
- new matching federal funds from the MaineCare expansion component of Dirigo,
- ongoing matching federal Medicaid funds, and

- a 4 percent “savings offset payment” on health carriers, excess loss carriers, and third party administrators to recover a portion of their premiums currently devoted to uncompensated care for use by the state to provide subsidies under Dirigo Health.⁴²

In 2002, even before the introduction of Dirigo Health, MaineCare was expanded using an 1115 HIFA waiver to cover childless adults up to 100 percent FPL. Funding for the expansion came from unused DSH funds, supplemented with tobacco-tax revenues. DSH funds come from the federal and state governments, as well as local tax appropriations. Beneficiaries obtained the full Medicaid benefit package through a primary care case-management program. The Dirigo Health plan built on this initial waiver in its expansion of coverage to both childless adults and those with children.²¹

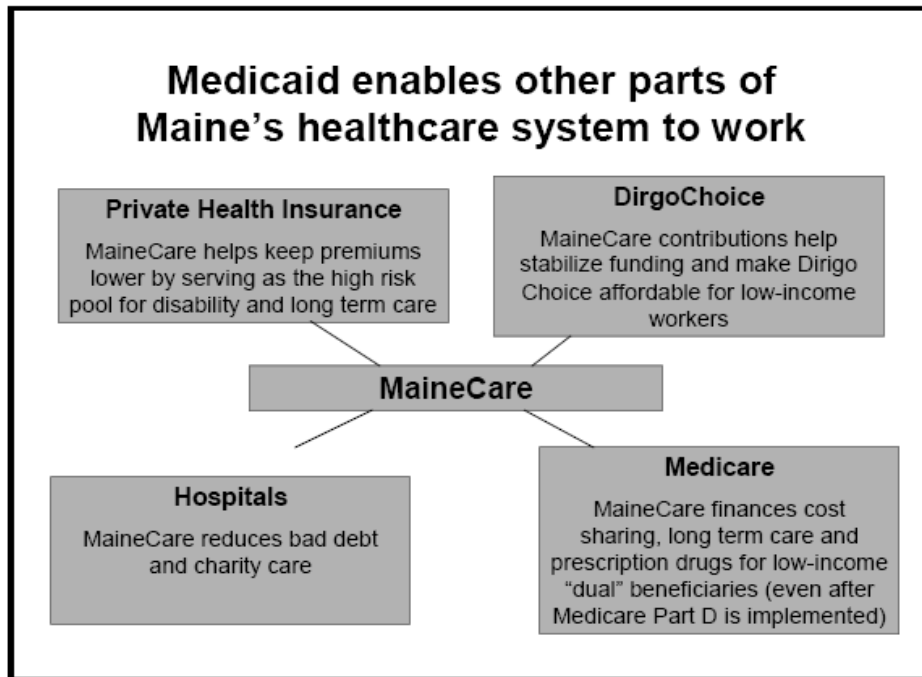
Maine: Rx Plus

In 2004 the state implemented the Maine Rx Plus program in which the state serves as pharmacy-benefits manager for residents who lack prescription-drug insurance and who have incomes up to 350 percent FPL. Through the use of its purchasing power the state obtains discounts for the uninsured. Expected savings range from 15 percent on brand-name drugs, up to 60 percent on generic drugs on the state’s Medicaid Preferred Drug List.

Source: Silow-Carroll, Sharon and Tanya Alteras, “Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing,” The Commonwealth Fund, 2004.

MaineCare covers one in five Maine residents and works as a critical component to the Dirigo Health Plan. In coordination with private health insurance, MaineCare contributes to keeping the number of uninsured individuals low and also reduces the amount of bad debt and charity care in the state. When hospitals and other health care providers give free care to the uninsured, they recoup their losses by charging more to commercial payers. This results in higher prices for both employers and employees when purchasing private, employment-based insurance policies. The following chart shows how MaineCare supports the entire health care system.⁴³

Figure 3.



Source: Saucier, Paul, "MaineCare and Its Role in Maine's Healthcare System," Kaiser Commission on Medicaid and the Uninsured, 2005.

Maine's state budget has been affected by the recession, and growing medical costs have led to increased costs in MaineCare. During the 2005 legislative session, there was some discussion regarding whether to delay implementation of the MaineCare expansions that were part of the Dirigo Health plan because of fiscal constraints. However, dedication to Dirigo Health and support from the public kept the MaineCare expansions from being abandoned. The legislature did adopt a number of cost-containment measures targeted at MaineCare during the last two years. These include:

- decreased or capped provider rates (only for certain provider groups, e.g., outpatient hospital and mental health providers);
- prior authorization requirements for all population groups;
- limitations on psychological services, physical therapy, occupational therapy, and chiropractic services for MaineCare parents and adults;
- tighter caps on personal care attendant hours and brain injury rehabilitative hours;
- implementation of a preferred drug list; and
- case management for high cost cases.⁶

While these changes have an impact on the lives and health care of enrollees, Maine's approach leans toward protecting eligibility standards for MaineCare enrollees. Policymakers and the public understand the critical role that Medicaid plays in Maine's health care system. Maine's Dirigo Health plan offers an example of how to manage rising costs, decrease the number of uninsured, and increase health care quality and access. While both MaineCare and Dirigo Health play distinct roles, the two programs compliment one another and contribute to the state's efforts to develop a system of high quality, affordable health insurance coverage for all Maine residents.

CONCLUSION

States have used a range of options to contain costs in their Medicaid programs. These include:

- increased cost sharing (e.g., premiums, copayments);
- cutting eligibility;
- restructuring or reducing health care benefits;
- disease-management and case-management programs;
- controls on costs of prescription drugs;
- premium assistance for employer-based insurance;
- tightening of fraud and abuse controls for providers and enrollees;
- state government provided re-insurance;
- freezing or reducing provider and managed care organization payments;
- delivery system changes;
- capping or halting enrollment for certain population groups; and
- application/enrollment process changes.

As Missouri works to redesign its Medicaid system, policymakers and the public must take into account the likely effects of redesign on individuals and systems. For many individuals, policy changes in Medicaid can result in lost coverage, going without needed health care, and accumulation of medical debt. These individual effects also cascade into the larger health care systems by creating a newly uninsured population with reduced access to primary care, higher rates of emergency room use, declining health, and greater levels of medical debt.¹² As Missouri policymakers consider multiple strategies for ensuring Medicaid solvency, other states' experiences may hold important lessons on the potential impacts of any given approach.

Appendix A

2005 HHS Federal Poverty Level Guidelines

Persons in Family Unit	100% FPL for the 48 Contiguous States and D.C.
1	\$ 9,570
2	12,830
3	16,090
4	19,350
5	22,610
6	25,870
7	29,130
8	32,390
For each additional person, add	3,260

SOURCE: Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

ENDNOTES

- ¹ John Iglehart, "The Dilemma of Medicaid," The New England Journal of Medicine, 22 May 2003 (2140-2148).
- ² Vernon K. Smith and Greg Moody, Medicaid in 2005: Principles & Proposals for Reform, Lansing, MI: Health Management Associates, February 2005.
- ³ Grantmakers in Health, Health and Fiscal Policy: Understanding Fiscal Policy: A Primer for Health Funders, Washington, DC: GIH, November 2004.
- ⁴ Elizabeth McNichol and Makeda Harris, Many States Cut Budgets as Fiscal Squeeze Continues, Washington, DC: Center on Budget and Policy Priorities, 2004.
- ⁵ Rockefeller Institute of Government and National Association of State Budget Officers, 2004.
- ⁶ Vernon Smith, et al., The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, October 2004.
- ⁷ The Commonwealth Fund, "Study: Health Spending Continues to Outpace Economic Growth," Washington Health Policy Week in Review, 27 June 2005, 30 June 2005
http://www.cmwf.org/healthpolicyweek/healthpolicyweek_show.htm.
- ⁸ Carmen DeNavas-Walt, Bernadette D. Proctor and Cheryl Hill Lee, Income, Poverty and Health Insurance Coverage in the United States: 2004. Current Population Reports: Consumer Income, US Census Bureau, U.S. Department of Commerce, August 2005.
- ⁹ The Kaiser Commission on Medicaid and the Uninsured, Key Facts-Medicaid Section 1115 Waivers: Current Issues, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2005.
- ¹⁰ Pamela Farley Short, Deborah R. Graefe and Cathy Schoen, Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem (#688), New York: The Commonwealth Fund, November 2003.
- ¹¹ Families USA, Paying a Premium: The Added Cost of Care for the Uninsured, Washington, DC: Families USA, June 2005.
- ¹² Bill Wright, et al., Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan (#848), New York: The Commonwealth Fund, July 2005.
- ¹³ Sharon Silow-Carroll, et al., Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey and Georgia (#565), New York: The Commonwealth Fund, 2002.
- ¹⁴ Samantha Artiga and Cindy Mann, Policy Brief-New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, March 2005.
- ¹⁵ Gene LeCouteur, et. al., The Impact of Medicaid Reductions in Oregon: Focus Group Insights, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, December 2004.
- ¹⁶ Samantha Artiga and Molly O'Malley, Issue Paper-Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2005.
- ¹⁷ Sharon Silow-Carroll and Tanya Alteras, Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing, New York: The Commonwealth Fund, October 2004.
- ¹⁸ Barbara Yondorf, A Framework for Considering Health Care Cost Containment, Washington, DC: National Conference of State Legislatures, July 2003.

- ¹⁹ Robert Seifert, The Basics of MassHealth, the Medicaid Program in Massachusetts, Boston: Massachusetts Medicaid Policy Institute, December 2004.
- ²⁰ Sharon Silow-Carroll and Tanya Alteras, Stretching State Health Care Dollars: Building on Employer-Based Coverage, New York: The Commonwealth Fund, October 2004.
- ²¹ Sharon Silow-Carroll and Tanya Alteras, Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds, New York: The Commonwealth Fund, October 2004.
- ²² Randall Bovbjerg, State Case Study: Medicaid and the 2003-05 Budget Crisis- A Look at How Massachusetts Responded, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, August 2005.
- ²³ John Holahan, et al., State Responses to Budget Crisis in 2004: An Overview of Ten States, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2004.
- ²⁴ Christopher J. Conover and Hester H. Davies, Occasional Paper No. 33: The Role of TennCare in Health Policy for Low-Income People in Tennessee, Washington, DC: The Urban Institute, February 2000.
- ²⁵ The Kaiser Commission on Medicaid and the Uninsured, Key Facts-Tennessee Section Waiver Amendment Proposal Fact Sheet, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, October 2004.
- ²⁶ Andy Schneider, Policy Brief- Tennessee's New "Medically Necessary" Standard: Uncovering the Insured?, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, July 2004.
- ²⁷ Leighton Ku and Vikki Wachino, The Potential Impact of Eliminating TennCare and Reverting to Medicaid: A Preliminary Analysis, Washington, DC: The Center on Budget and Policy Priorities, November 2004.
- ²⁸ Kaiser Family Foundation, "Medically Needy Beneficiaries Will Be Allowed to Stay in TennCare, Tennessee Gov. Bredesen Says," Kaisernetwork.org: Kaiser Daily Health Policy Report, 11 August 2005, 11 August 2005 <http://www.kaisernetwork.org>.
- ²⁹ Kaiser Family Foundation, "TennCare Advocates To Present Closing Arguments Related to Consent Decree," Kaisernetwork.org: Kaiser Daily Health Policy Report, 27 July 2005, 28 July 2005 <http://www.kaisernetwork.org>.
- ³⁰ Kaiser Family Foundation, "Recent TennCare Developments," Kaisernetwork.org: Kaiser Daily Health Policy Report, 20 July 2005, 22 July 2005 <http://www.kaisernetwork.org>.
- ³¹ Alshadye Yemane and Ian Hill, Recent Changes in Health Policy for Low-Income People in Florida: State Update No. 16, Washington, DC: The Urban Institute, April 2002.
- ³² Barbara Ormond, State Responses to Budget Crises in 2004: Florida, Washington, DC: The Urban Institute, February 2004.
- ³³ Donna Cohen Ross, Update on the Florida SCHIP Enrollment Freeze, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, July 2004.
- ³⁴ Kaiser Family Foundation, "Florida Lawmakers Might Loosen Enrollment Rules for KidCare," Kaisernetwork.org: Kaiser Daily Health Policy Report, 21 April 2005, 7 September 2005 <http://www.kaisernetwork.org>.
- ³⁵ Kaiser Family Foundation, "Florida Gov. Bush Signs Bill To Expand KidCare Enrollment Period," Kaisernetwork.org: Kaiser Daily Health Policy Report, 21 June 2005, 7 September 2005 <http://www.kaisernetwork.org>.
- ³⁶ Kaiser Family Foundation, "Florida House Approves Medicaid Overhaul; Governor To Consider Legislation," Kaisernetwork.org: Kaiser Daily Health Policy Report, 10 May 2005, 7 September 2005 <http://www.kaisernetwork.org>.

³⁷ Kaiser Family Foundation, "Florida Makes Plans for Pilot Medicaid Managed Care Program in Two Counties," Kaisernetwork.org: Kaiser Daily Health Policy Report, 27 July 2005, 28 July 2005 <http://www.kaisernetwork.org>.

³⁸ Agency for Health Care Administration, "Florida Takes Next Step in Bold Plan to Reform Medicaid," Communications, 31 August 2005, 1 September 2005 <http://www.fdhc.state.fl.us>.

³⁹ Florida Agency for Health Care Administration, Florida Medicaid Reform: Application for 115 Research and Demonstration Waiver, 30 August 2005, 1 September 2005 http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml.

⁴⁰ Tom Arnold, "Integrating Consumer-Directed Health Care Strategies into Publicly Sponsored Coverage," 18th Annual State Health Policy Conference. National Association for State Health Policy. Nashville, TN, 7 August 2005, Florida Agency for Health Care Administration.

⁴¹ Joan Alker, "Medicaid Reform: What Could it Mean for Florida's Health Care System?" Medicaid Symposium. Miami, FL, 4 February 2005, Georgetown Health Policy Institute.

⁴² Kaiser Family Foundation, "Maine Legislature Gives Preliminary Approval to Governor's Universal Health Plan," Kaisernetwork.org: Kaiser Daily Health Policy Report, 13 June 2003, 16 June 2003 <http://www.kaisernetwork.org>.

⁴³ Paul Saucier, MaineCare and Its Role in Maine's Healthcare System, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2005.

BIBLIOGRAPHY

- Agency for Health Care Administration. "Florida Takes Next Step in Bold Plan to Reform Medicaid." Communications. 31 August 2005. 1 September 2005 <http://www.fdhc.state.fl.us>.
- Alker, Joan. "Medicaid Reform: What Could it Mean for Florida's Health Care System?" Medicaid Symposium. Miami, FL. 4 February 2005. Georgetown Health Policy Institute.
- Arnold, Tom. "Integrating Consumer-Directed Health Care Strategies into Publicly Sponsored Coverage." 18th Annual State Health Policy Conference. National Association for State Health Policy. Nashville, TN. 7 August 2005. Florida Agency for Health Care Administration.
- Artiga, Samantha and Cindy Mann. Policy Brief-New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, March 2005.
- Artiga, Samantha and Molly O'Malley. Issue Paper-Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2005.
- Bailitt, Michael, Laurie Burgess and Tricia Roddy. State Budget Cuts and Medicaid Managed Care: Case Studies of Four States. Portland, ME: National Academy for State Health Policy, June 2004.
- Bergman, David, Claudia Williams and Cynthia Pernice. SCHIP Changes in a Difficult Budget Climate: A Three-State Site Visit Report. Portland, ME: National Academy for State Health Policy, April 2004.
- Blue Cross Blue Shield Association. The Uninsured in America. Chicago: Blue Cross Blue Shield Association, January 2005.
- Bovbjerg, Randall. State Case Study: Medicaid and the 2003-05 Budget Crisis- A Look at How Massachusetts Responded. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, August 2005.
- Center for Studying Health System Change. Community Report: Boston, MA: Health Care Market Stabilizes, but Rising Costs and State Budget Woes Loom in Boston. Washington, DC: Center for Studying Health System Change, Fall 2003.
- Cohen Ross, Donna. Update on the Florida SCHIP Enrollment Freeze. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. July 2004.
- Conover, Christopher J. and Hester H. Davies. Occasional Paper No. 33: The Role of TennCare in Health Policy for Low-Income People in Tennessee. Washington, DC: The Urban Institute, February 2000.
- Coughlin, Teresa and Stephen Zuckerman. "Three Years of State Fiscal Struggles: How Did Medicaid and SCHIP Fare?" Health Affairs. 16 August 2005 (385-398).
- DeNavas-Walt, Carmen, Bernadette D. Proctor and Cheryl Hill Lee. Income, Poverty and Health Insurance Coverage in the United States: 2004. Current Population Reports: Consumer Income. US Census Bureau, U.S. Department of Commerce, August 2005.
- Families USA Foundation. Medicaid and the Continuing Budget Fight: Principles to Guide Medicaid Action. 8 June 2005. 11 August 2005 http://www.familiesusa.org/site/PageServer?pagename=Medicaid_Act.
- Families USA. Paying a Premium: The Added Cost of Care for the Uninsured. Washington, DC: Families USA, June 2005.
- Florida Agency for Health Care Administration. Florida Medicaid Reform: Application for 115 Research and Demonstration Waiver. 30 August 2005. 1 September 2005 http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml.
- Friedenzohn, Isabel et al. State of the States: Cultivating Hope in Rough Terrain. Washington, DC: Academy Health, January 2004.

Grantmakers in Health. Health and Fiscal Policy: Understanding Fiscal Policy: A Primer for Health Funders. Washington, DC: GIH, November 2004.

Hargraves, J. Lee. Tracking Report No. 11: Trends in Health Insurance Coverage and Access Among Black, Latino and White Americans, 2001-2003. Washington, DC: Center for Studying Health System Change, October 2004. 28 October 2004 <http://www.hschange.org>.

Holahan, John and Mary Beth Pohl. Discussion Papers- States as Innovators in Low-Income Health Coverage. Washington, DC: The Urban Institute, June 2002.

Holahan, John et al. State Responses to Budget Crisis in 2004: An Overview of Ten States. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2004.

Iglehart, John K. "The Dilemma of Medicaid." The New England Journal of Medicine. 22 May 2003 (2140-2148).

Joel Ferber. Medicaid is Still Good for Missouri. St. Louis, MO: Legal Services of Eastern Missouri, Inc., December 2004.

Kaiser Family Foundation. "Federal Judge Issues Partial Ruling in TennCare Consent Decree Case." Kaisernetwork.org: Kaiser Daily Health Policy Report. 01 August 2005. 1 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Federal Judge Says Tennessee Can Proceed With Plans to Eliminate TennCare Coverage for 323,000 People." Kaisernetwork.org: Kaiser Daily Health Policy Report. 13 April 2005. 6 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Federal, State Lawmakers Address Rising Medicaid Costs." Kaisernetwork.org: Kaiser Daily Health Policy Report. 2 August 2005. 2 August 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Florida Gov. Bush Signs Bill To Expand KidCare Enrollment Period." Kaisernetwork.org: Kaiser Daily Health Policy Report. 21 June 2005. 7 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Florida House Approves Medicaid Overhaul; Governor To Consider Legislation." Kaisernetwork.org: Kaiser Daily Health Policy Report. 10 May 2005. 7 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Florida Lawmakers Might Loosen Enrollment Rules for KidCare." Kaisernetwork.org: Kaiser Daily Health Policy Report. 21 April 2005. 7 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Florida Makes Plans for Pilot Medicaid Managed Care Program in Two Counties." Kaisernetwork.org: Kaiser Daily Health Policy Report. 27 July 2005. 28 July 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Maine Legislature Gives Preliminary Approval to Governor's Universal Health Plan." Kaisernetwork.org: Kaiser Daily Health Policy Report. 13 June 2003. 16 June 2003 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Medically Needy Beneficiaries Will Be Allowed to Stay in TennCare, Tennessee Gov. Bredesen Says." Kaisernetwork.org: Kaiser Daily Health Policy Report. 11 August 2005. 11 August 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "News Coverage of Developments in State Medicaid Programs." Kaisernetwork.org: Kaiser Daily Health Policy Report. 21 July 2005. 7 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Recent Developments in State Medicaid Programs." Kaisernetwork.org: Kaiser Daily Health Policy Report. 16 August 2005. 16 August 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Recent TennCare Developments." [Kaisernetwork.org: Kaiser Daily Health Policy Report](http://www.kaisernetwork.org). 20 July 2005. 22 July 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Restrictions on Prescription Drugs for Florida Medicaid Beneficiaries Could Harm Mentally Ill, Advocates Say." [Kaisernetwork.org: Kaiser Daily Health Policy Report](http://www.kaisernetwork.org). 14 June 2005. 7 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "TennCare Advocates To Present Closing Arguments Related to Consent Decree." [Kaisernetwork.org: Kaiser Daily Health Policy Report](http://www.kaisernetwork.org). 27 July 2005. 28 July 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Tennessee Governor Announces TennCare Will End Coverage for About 300,000, Change Benefits for Another 400,000." [Kaisernetwork.org: Kaiser Daily Health Policy Report](http://www.kaisernetwork.org). 11 January 2005. 6 September 2005 <http://www.kaisernetwork.org>.

Kaiser Family Foundation. "Tennessee Governor Meets with CMS Officials to Discuss Possible Changes to TennCare." [Kaisernetwork.org: Kaiser Daily Health Policy Report](http://www.kaisernetwork.org). 10 January 2005. 6 September 2005 <http://www.kaisernetwork.org>.

Ku, Leighton and Vikki Wachino. [The Potential Impact of Eliminating TennCare and Reverting to Medicaid: A Preliminary Analysis](#). Washington, DC: The Center on Budget and Policy Priorities, November 2004.

LeCouteur, Gene, et. al. [The Impact of Medicaid Reductions in Oregon: Focus Group Insights](#). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, December 2004.

Massachusetts Medicaid Policy Institute. [Issue Brief: The MassHealth Waiver](#). Boston: Massachusetts Medicaid Policy Institute, April 2005.

Massachusetts Medicaid Policy Institute. [MassHealth: It's Good for Business: Ten Facts the Employer Community Should Know About the Massachusetts Medicaid Program: Executive Summary](#). Boston: Massachusetts Medicaid Policy Institute, June 2005.

Massachusetts Medicaid Policy Institute. [MMPI Budget Bulletin: Fact Sheet: The FY 2005 Massachusetts Medicaid Program Budget](#). Boston: Massachusetts Medicaid Policy Institute, 2004.

McNichol, Elizabeth, and Makeda Harris. [Many States Cut Budgets as Fiscal Squeeze Continues](#). Washington, DC: Center on Budget and Policy Priorities, 2004.

Ormond, Barbara. [State Responses to Budget Crises in 2004: Florida](#). Washington, DC: The Urban Institute, February 2004.

Rosenbaum, Sara, Peter Shin and Julie Darnell. [Issue Paper-Economic Stress and the Safety Net: A Health Center Update](#). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, June 2004.

Rosenthal, Jill and Cynthia Pernice. [Designing Maine's DirigoChoice Benefit Plan: Striving to Improve Health at an Affordable Price](#). Portland, ME: National Academy for State Health Policy, December 2004.

Rosenthal, Jill and Cynthia Pernice. [Dirigo Health Reform Act: Addressing Health Care Costs, Quality and Access in Maine](#). Portland, ME: National Academy for State Health Policy, June 2004.

Rowland, Diane. "Medicaid: Addressing the Future." [Testimony. U.S. Senate Special Committee on Aging](#). Washington, DC. 28 June, 2005. The Kaiser Commission on Medicaid and the Uninsured.

Saucier, Paul. [MaineCare and Its Role in Maine's Healthcare System](#). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2005.

Schneider, Andy. [Policy Brief- Tennessee's New "Medically Necessary" Standard: Uncovering the Insured?](#). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, July 2004.

Schoen, Cathy, et al. "Insured But Not Protected: How Many Adults are Underinsured?" [Health Affairs](http://content.healthaffairs.org). 14 June 2005. 16 June 2005 <http://content.healthaffairs.org>.

Seifert, Robert. The Basics of MassHealth, the Medicaid Program in Massachusetts. Boston: Massachusetts Medicaid Policy Institute, December 2004.

Shirk, Cindy. Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP. Portland, ME: National Academy for State Health Policy, February 2004.

Short, Pamela Farley, Deborah R. Graefe and Cathy Schoen. Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem (#688). New York: The Commonwealth Fund, November 2003.

Silow-Carroll, Sharon and Tanya Alteras. Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness (#783). New York: The Commonwealth Fund, October 2004.

Silow-Carroll, Sharon and Tanya Alteras. States in Action: A Quarterly Look at Innovations in Health Policy. New York: The Commonwealth Fund, May 2005.

Silow-Carroll, Sharon and Tanya Alteras. Stretching State Health Care Dollars: Building on Employer-Based Coverage. New York: The Commonwealth Fund, October 2004.

Silow-Carroll, Sharon and Tanya Alteras. Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds. New York: The Commonwealth Fund, October 2004.

Silow-Carroll, Sharon and Tanya Alteras. Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing. New York: The Commonwealth Fund, October 2004.

Silow-Carroll, Sharon et al. Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey and Georgia (#565). New York: The Commonwealth Fund, 2002.

Smith, Vernon et al. The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, October 2004.

Smith, Vernon K. and Greg Moody. Medicaid in 2005: Principles & Proposals for Reform. Lansing, MI: Health Management Associates, February 2005.

Swartz, Katherine. Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers (#820). New York: The Commonwealth Fund, July 2005.

The Commonwealth Fund. "Tennessee Governor Explains TennCare Coverage Cuts." Washington Health Policy Week in Review. 27 June 2005. 30 June 2005 <http://www.cmf.org>.

The Commonwealth Fund. "Optional Spending Big but Elusive Target in Medicaid." Washington Health Policy Week in Review. 5 July 2005. 28 July 2005 <http://www.cmf.org>.

The Commonwealth Fund. "Study: Health Spending Continues to Outpace Economic Growth." Washington Health Policy Week in Review. 27 June 2005. 30 June 2005 http://www.cmf.org/healthpolicyweek/healthpolicyweek_show.htm.

The Kaiser Commission on Medicaid and the Uninsured. Issue Paper- Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, June 2005.

The Kaiser Commission on Medicaid and the Uninsured. Key Facts-Maine Section 1115 Waiver. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2003.

The Kaiser Commission on Medicaid and the Uninsured. Key Facts-Medicaid Section 1115 Waivers: Current Issues. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2005.

The Kaiser Commission on Medicaid and the Uninsured. Key Facts-Tennessee Section Waiver Amendment Proposal Fact Sheet. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, October 2004.

The National Governors Association. Short-Run Medicaid Reform from the National Governors Association. 29 August 2005.

The Tennessee Health Care Campaign. "The Governor's Plan for TennCare." June 2005. 1 September 2005. http://www.tennicare.org/GovernorsPlan/fact_sheet.pdf.

The United States Medicaid Commission. Report to the Honorable Secretary Michael O. Leavitt, Department of Health and Human Service and The United States Congress. 1 September, 2005.

Wadhvani, Anita. "Free drugs for those off TennCare have a catch." Tennessean 26 August 2005 <http://tennessean.com>.

Wright, Bill et al. Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan (#848). New York: The Commonwealth Fund, July 2005.

Yemane, Alshadye and Ian Hill. Recent Changes in Health Policy for Low-Income People in Florida: State Update No. 16. Washington, DC: The Urban Institute, April 2002.

Yondorf, Barbara, Laura Tobler and Leah Oliver. State Options for Expanding Health Care Access. Washington, DC: National Conference of State Legislatures, March 2004.

Yondorf, Barbara. A Framework for Considering Health Care Cost Containment. Washington, DC: National Conference of State Legislatures, July 2003.

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