THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Medicaid and State Budgets: A Case Study of Idaho

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When Congress adopted the Children's Health Insurance Program (CHIP) in 1997, then Idaho Governor Batt (R) moved quickly to expand the Medicaid program with the new federal funds. This action enabled Idaho children to enjoy the comprehensive benefits and protections offered by Medicaid, and ensured children could enroll immediately without waiting for the establishment of a new program. After the development of an effective outreach program in late 1999, the pace of CHIP enrollment dramatically increased in Idaho, with 11,487 enrolled as of August 2001. In addition, for every 5 children who enrolled in Medicaid after CHIP was adopted, 4 children enrolled in Medicaid and one enrolled in CHIP. Enrollment in CHIP and Medicaid programs increased by more than 40 percent in just two years (August 1999 to August 2001).

During this period of enrollment growth, Idaho was also experiencing major economic growth. Revenues exceeded spending for 1999, 2000 and were expected to in 2001 as well. In 2001, legislators enacted the largest tax cut in Idaho's history, valued at more than $100 million a year. Despite increased revenues and the appearance of a healthy state budget, state legislators began to look more closely at the Medicaid program as it grew in size and cost to the state budget. As more uninsured children enrolled in Idaho's Medicaid/CHIP program, conservative legislators grew concerned about the rising cost of Medicaid and looked for ways to cut the program. Although long-term care and pharmaceutical drug costs are the most rapidly rising costs in Medicaid, and children are the least expensive population to insure, the 2001 Legislature mainly targeted the CHIP program to cut. The 2001 Legislature adopted a bill that limits the number of children eligible for the program, eliminates state-funded outreach programs, limits the number of mental health patients covered, and provides new options to the state Department of Health and Welfare (DHW) to limit the program in the future. This bill was passed at the same time Idaho believed it had a $330 million budget surplus.

While a growing Medicaid budget may be cause for concern, many argue that limiting services by decreasing eligibility levels and denying coverage for certain benefits will leave many low-income Idaho residents without access to health care coverage. Large uninsured populations often put additional strains on the economic health of a state by causing individuals with preventable or treatable illnesses to forgo treatment or obtain care in a more expensive setting, such as an emergency room.

I. Description of the state, the state government, and the state government decision process

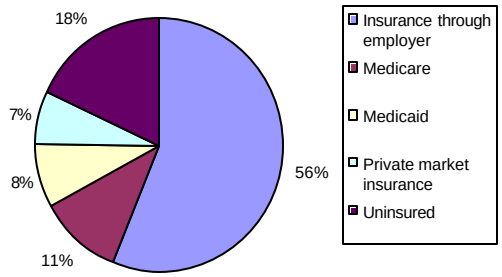
State Demographics

Idaho is home to 1.3 million residents, 28.5 percent are children and 11.3 percent are over 65.[1] Idaho is a poor, rural, and mostly white state. Idaho's Hispanic population, its largest minority group, represents eight percent of the total population. Native Americans represent 1.5 percent of the population, and Asian and African American populations are negligible.[2] Unlike the rest of the nation, which saw its poverty rate slightly decrease or remain stagnant during the 1990 boom years, Idaho's poverty rate rose during this period.[3] Rural areas -- once dependent on the now defunct mining industry -- were the hardest hit, with some rural counties enduring 20

percent or higher poverty rates. Per capita income in Idaho is significantly lower than the national average in 1996 ($24,436 a year). Per capita income in Idaho urban areas is $21,773 and in rural areas it is $16,513, just two-thirds of the national average.[4] Forty percent of the non-elderly population earns less than 200 percent of the federal poverty level (FPL).[5]

Idaho was the one of the few states in the nation that saw an increase in its percentage of uninsured residents in 1999, the most recent year figures were available.[6] With nearly one in five uninsured, Idaho has the ninth highest percentage of uninsured children in the U.S.[7] Most (56 percent) Idahoans receive insurance through their employer, another 7 percent purchase individual health insurance on the private market, 11 percent are covered by Medicare, and 8 percent are covered by Medicaid. Forty percent of the uninsured individuals are members of families who make less than 100 percent of the Federal Poverty Level (FPL), 30 percent are in families earning between 100 percent and 200 percent of the FPL, and 30 percent make at or above 200% of the FPL.

How Idaho residents access health care coverage, 1997-1999[8]



Idaho state government

The bicameral Idaho Legislature meets every year for three months and makes funding and policy decisions about education, economic development, revenue, health and human services, transportation, public safety, and natural resources. The Legislature is composed of 35 Senators and 70 Representatives elected for two-year terms. Eighty-five percent of Idaho legislators are members of the Republican Party, as is Idaho Governor Dirk Kempthorne. The Idaho Democratic party is not involved in major state policy decisions. However, Idaho's legislators do not always walk in lockstep and rural/urban, Libertarian/religious conservative and other splits exist. Few legislators are career politicians and most are farmers, ranchers, businesspeople, lawyers, doctors, sales people, loggers, or teachers. Legislators share administrative staff and only those in leadership positions have policy staff support.

Idaho state government decision-making process

State agencies develop their budget request in the summer before the January legislative session. The Governor's office reviews the budget and submits his executive budget to the Legislature at the beginning of the session. The Joint Finance Appropriate Committee (JFAC) begins budget hearings and sends final appropriations bills to the floor.

Over the past two years, the JFAC committee has been using Idaho regulations that allow political parties to meet in closed caucuses. This regulation essentially allows the Republican JFAC committee members to meet in private, unannounced meetings while conducting committee business. In addition, the JFAC began adding policy directives to its appropriations bills during these closed sessions.

This strategy is very effective for those who want to cut the Medicaid program. When the Senate health care committee took up a bill to impose cost-sharing in the Medicaid program, low-income advocates successfully defeated the bill by staging an emotional public hearing and drawing press attention to the issue. JFAC has been able to avoid public hearings and press attention. The public and other legislators saw the final Medicaid appropriations bill only when it came to the floor for final action.

II. Fiscal history of the state in the last five years

Overall Changes in the Economy

During the 1990s, Idaho had one of the nation's strongest state economies. The state enjoyed a low-unemployment rate, the third highest population growth rate in the nation, and some increases in per capita income. However, like the national economy, Idaho's economy has been growing at a slower pace over the past two years. In addition, the statewide figures about Idaho's economy are somewhat misleading because most of the increased economic activity occurred in just two populous counties in Southwestern Idaho (Boise and Canyon). These counties enjoyed an influx of new manufacturing and high technology jobs.

The rural areas of Idaho, which represent almost 90 percent of the state's geography, have seen only modest economic growth and in some cases declining economies. Unemployment rates in some counties, particularly those dependent on timber and mining, is in the double-digits. Per capita income in rural Idaho is three-fourths of what it is in the urban areas. Median household income in rural counties is similarly lower than urban Idaho, which exceeds the national average.[9] Employment in industries that have been the mainstays of Idaho's rural economy, such as timber, mining, and farming, is declining and the only new industry, which is limited to a few rural counties, is low-wage tourism.

Like the national economy, Idaho's economy has begun to decline in 2001. Several key industries announced layoffs in the early part of 2001 and Idaho's Department of Commerce (DOC) has downgraded its quarterly economic forecasts twice in 2001. Personal income and employment growth has started to decline and the DOC expects it to decline until 2003. The DOC also projects higher unemployment from 2001 to 2003.

Tax cuts and the declining economy's impact on state revenue

Idaho primarily relies on payments from the federal government ($1.1 billion in FY 2001), individual income taxes ($916 million in FY 2001), and its sales tax ($639 million in FY 2001) to pay for its state services. The amount that Idaho receives from the federal government is only

slightly smaller than the $1.8 billion that it raised with its individual income tax, sales tax, corporate income tax, property tax, and other taxes in FY 2001.[10] About 40 percent of these revenues are spent on education, 26 percent on health and welfare services, 12 percent on transportation, 11 percent on public safety and corrections, and the rest on other agencies and general government.[11]

In the past two years, Idaho's employment growth has exceeded expectation, resulting in higher income tax payments to the state. In 2000, Idaho enjoyed a surplus exceeding $179 million. The 2001 Idaho legislature enjoyed a surplus of $341 million, all of which was either appropriated for the FY02 budget or spent to meet FY01 needs. The funds used in FY01 went towards the state's building maintenance and construction fund ($65 million), a Medicaid supplemental transfer ($35 million), the state capitol renovation project ($32 million), and other one-time expenditures. The rest of the surplus was used for the fiscal year 2002 and 2003 budgets and was spent on tax relief ($121 million), a transfer to the state's Budget Stabilization Fund or "rainy day" fund ($20 million), and several one-time expenditures for 2002 ($52 million).[12] The legislature approved the tax cuts despite the fact that state economists agreed that permanent tax cuts in excess of $60 million would not be sustainable.[13]

When the 2001 legislative session ended on March 30, legislators returned to their homes believing that they had crafted a FY02 budget that left $64 million dollars unspent.[14] But, as the year progressed, tax revenues began to decline and the $64 million dollars in unspent funds were needed to continue FY01 operations. In August, Governor Kempthorne announced that all state agencies would need to cut 2 percent from their budgets by September 24, 2001. Agencies slashed $36 million from their budgets, including $4.4 million from Medicaid.[15]

A recent report by the Governor's Division of Financial Management suggests that more budget cuts may be required. The report explores the impact on the state budget of the September 11 terrorist attacks and predicts job losses that could drain the state's total personal income by more than $520 million between 2002 and 2004.[16] Idaho's tourist economy has been particularly hard hit; business at one of Idaho's largest and most popular resorts has nearly collapsed since September 11.[17] At the end of October, the state budget was nearly $18 million in the red as revenues did not meet targets. Governor Kempthorne warned agency directors that he will require more budget cuts if forthcoming economic reports show further revenue declines.

Tobacco settlement resources for health care

Under the multi-state tobacco settlement agreement, the tobacco industry was ordered to pay Idaho $8.7 million initially and from $23.3 and $30.5 million each year thereafter. Governor Kempthorne immediately invested the initial and first year payment into the state's Budget Stabilization Fund, the state's rainy day fund. In 2000, the Idaho state legislature created the "Idaho Millennium Fund," for subsequent payments and directed that the principle value of the tobacco settlement placed in the Budget Stabilization Fund be moved to the Millennium Fund. The 2000 bill also gave authority to the state treasurer to invest the funds, limited disbursements to 5 percent annually, and allowed only one-time disbursements as approved by the state legislature. The state legislature set no guidelines on how the funds must be spent and the Governor's budget director acknowledges that the Millennium Fund is "on the table."[18]

In 2000, the legislature spent $2.3 million of the funds, primarily on tobacco cessation programs. It allocated $735,000 to the Catastrophic Health Care Cost Program for tobacco related cancer and respiratory treatment. In 2001, the legislature appropriated $2.8 million of the tobacco settlement funds, again mostly for tobacco cessation efforts. The 2001 legislature also created a study committee to recommend how the legislature should use the tobacco money. This committee met once in August 2001 and heard updates on how the money is currently being spent. The committee also plans to publicize a request for proposals for the tobacco money and decided to meet again in December.

Currently, there is $53 million in the Millennium Fund, and that amount will soon rise to $73 million. By the end of fiscal year 2003, the Millennium Fund will have $100 million.[19] As the Idaho budget crisis continues, legislators may be tempted to use the funds to solve budget problems. If this occurs, there is no guarantee that the funds will be spent on tobacco cessation or health care programs.

III. Description of the Medicaid Program

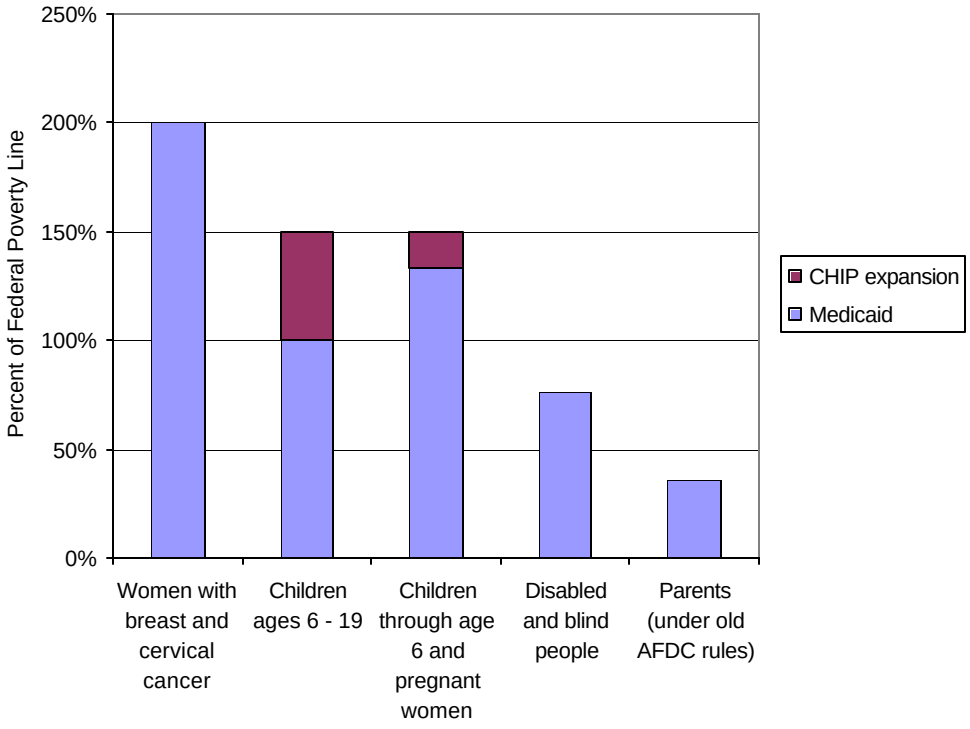
Idaho's Medicaid program, which serves over 100,000 individuals, makes up a significant and growing portion of the state budget.[20] However, Idaho receives one of the most generous match rates in the country for its Medicaid program: the federal government pays 71 percent of the cost of the general Medicaid program and 80 percent of the cost of the CHIP program. For all Medicaid programs combined, Idaho's general fund pays just 28.3 percent of the total cost.[21] In 2001, Idaho spent $607 million on Medicaid -- but only $200 million (or 11 percent of the state general fund) of this was from state dollars. Due to higher costs of nearly all Medicaid services and increased enrollment due to the new Children's Health Insurance Program and simplified application procedures for children, the Medicaid budget is projected to grow to $1 billion by 2006; approximately $300 million will come from state funds.[22]

Idaho spends 59.9 percent of Medicaid allocated dollars on federal mandates, 13.5 percent from state mandates given by the Legislature, and 26.6 percent from state mandates implemented administratively.[23] Although Idaho covers many optional services in its Medicaid program, Medicaid per client spending using state money is among the tenth lowest in the nation.[24] At the same time, Idaho's administrative costs are the second highest in the nation at 9 percent of overall program spending.[25]

Idaho improved its Medicaid program in 1997 when it chose to expand the Medicaid program beyond the federally mandated eligibility levels by using the CHIP block grant funds. Idaho's then Governor Batt made an executive decision to expand the Medicaid program, saying that the state should move quickly to use the new federal money and that expanding the Medicaid program was the fastest option. In the 1998 legislative session, the legislative budget committee voted to deny the state match required to draw down the federal CHIP funds. However, less than a week later, the committee voted 17-3 to reverse its decision to eliminate CHIP due to public pressure.

The expansion of Medicaid in 1997 resulted in new eligibility levels set at 150 percent of the Federal Poverty Line for children 19 years and younger. Previously, the eligibility levels were set at the federal minimum levels and 19 year olds were not covered. While this was an important expansion for the uninsured in Idaho, Idaho is one of only 12 other states with CHIP eligibility level below 200 percent of the Federal Poverty Level. In 2001, the Idaho Legislature expanded the program again by offering coverage to women with breast and cervical cancer in families earning up to 200 percent of the federal poverty line.

Idaho Medicaid eligibility, 2001



Idaho offers a fairly comprehensive benefit package to those it covers in the Medicaid program. In addition to the federally mandated benefits, which Idaho must provide to receive federal funding, Idaho also covers optional benefits. Some of these benefits include pharmaceutical coverage, adult dental care, and developmentally disabled services. Most of these optional services are required by state mandates that are enacted through state statutes. Other optional benefits, such as mental health coverage, developmental disability services, and nursing facilities for adults are optional services administratively imposed on the Medicaid program.

In 1993, Idaho adopted a managed care program and received a federal waiver to implement the program. Idaho currently has over 30,000 of its Medicaid beneficiaries in a managed care program. All of these individuals are in a primary case management program (PCCM) called "Healthy Connections." The goal of this program is to match clients with a primary care physician who will make all referrals of the client to various types of medical care needs. The payment from the state is given separately for each health care visit similar to a fee-for-service

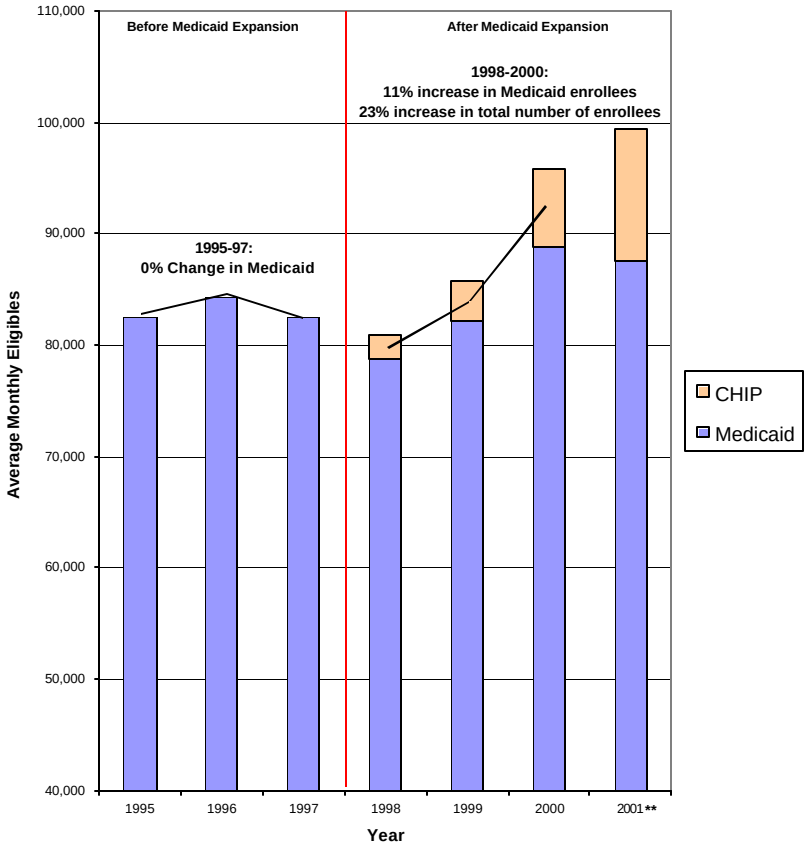
payment. In Idaho, all PCPs receive $3.50 per month per Healthy Connections beneficiary. The program is designed to provide comprehensive and preventative care, while providing utilization control for medical services. One report found that this program decreases the cost of Medicaid patients due to reduced hospitalizations, emergency room visits and specialty visits.[26]

To serve low-income families better by making Medicaid more accessible, the Department of Health and Welfare recently shortened the application form from 17 to 4 pages, simplified application procedures, and dramatically increased outreach efforts. DHW also eliminated the face-to-face interview requirement, allowed self-declaration of income, permitted 12-month continuous eligibility, and created mail-in applications. However, the DHW has yet to remove the $5,000 assets test for Medicaid or adopt presumptive eligibility. This makes Idaho one of only five other states in the nation to have an asset tests for children applying for the program.

Enrollment Practices for Children	**Idaho's Medicaid and SCHIP Program?**
Fact to Face interview	NO
Asset Testing	YES
Presumptive Eligibility	NO
12-month Continuous Eligibility	YES
Self-Declaration of Income	YES

Idaho's Medicaid program has been growing at a faster rate since the outreach program began for CHIP and the application process was simplified. Enrollment figures for Medicaid and CHIP have consistently increased in the past 4 to 5 years. More than 10,000 children have received coverage in the CHIP program since its inception in 1997.

Average Monthly Enrolled Children in the Medicaid Program: Before and After Medicaid Expansion using CHIP Funds

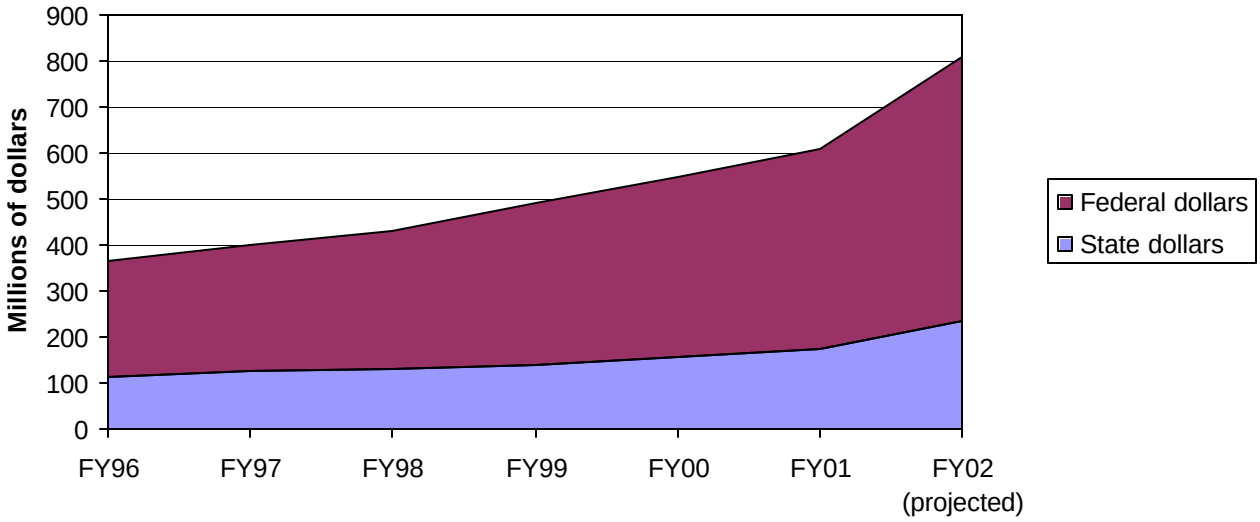


** Data for 2001 was only available up through August. Data for September through December was calculated by applying the rate of increase for CHIP and Medicaid data from January 2001 through to August 2001.

IV. Conflicting Opinions on What Drives Medicaid Costs

After a steady rate of spending growth between 1996 and 1999, Medicaid spending began to significantly increase in 2000. Legislators are keenly aware of the increasing cost of Medicaid and the Medicaid budget has been key issue of public debate during the last two legislative sessions. Newspaper headlines like "Medicaid's unchecked growth" and comments from legislators like Senator Mel Richardson (R – Idaho Falls) that Medicaid costs are "spiraling out of control" have fueled the sometimes-panicked tone of the public debate.[27]

Idaho Annual Medicaid Spending, Fiscal Years 1996 to 2002[28]



However, even before children began to rapidly enroll in Idaho's CHIP program in 1999, legislators worked to weaken the Medicaid program. These legislators, who form the right wing of Idaho's Republican party, are ideologically opposed to public health insurance programs and were furious when then Governor Batt administratively expanded the state's Medicaid program with the CHIP block grant. In 1997, under pressure from the right wing of his party, Governor Batt unveiled a package containing 34 consolidated proposals to save costs in the Medicaid program.[29] However, Governor Batt did not put his political weight behind the cuts and no major cuts were made to the Medicaid program in the 1998 legislative session. Similarly, in 1999, no major cuts were made to Medicaid.

After the 1999 session, Governor Kempthorne began a strategy to underfund Idaho's Medicaid program; both his FY00 and FY01 Medicaid budgets have required supplemental budgets. For FY00, the Governor proposed $11 million dollars less than the Medicaid program ultimately needed. When the Medicaid program required a supplemental budget to make it through the fiscal year, the legislature provided only $6 million.[30] In 2000, the Governor proposed $27 million less than the Department of Health and Welfare said it needed for the Medicaid program for FY01.[31] The FY01 Medicaid budget ultimately fell short by $33 million, but the legislature provided the full supplemental needed.[32]

Insufficient funding requires that the Department of Health and Welfare (DHW) request a supplemental budget during the legislative session to continue Medicaid services. Because these supplemental budgets are considered separately from the Governor's budget, supplemental budget requests receive much more attention than requests in the Governor's budget do. By forcing the Department of Health and Welfare to request supplemental funding, the Governor ensures that Medicaid funding issues will be a central budget issue.

The Governor's strategy to draw more attention to the state's Medicaid budget worked, In 2000, the state's joint budget committee spent much of the year attempting to cut $27 million from the Medicaid program. The committee was accused of being secretive and not hearing the public's voice. Ultimately, the committee appropriated $600,000 for a broad, intensive review of the Medicaid program by an independent research group rather than proposing any major cuts in Medicaid. The committee did direct the Department of Health and Welfare to continue to look for ways to administratively cut the Medicaid program.

The report that resulted from the committee's appropriation, written by the Lewin Group and Sjoberg Evashenk Consulting, LLC and released in November 2000, both affirmed the options identified by the task force committee and DHW and offered new program options. The report suggested that Idaho could cut from $4.7 to $6.7 million a year from its Medicaid budget by shifting some costs to the federal government, reducing spending on prescription drugs and pharmacist services, expanding the Medicaid managed care program, and taking other steps.

Some Republicans were frustrated with the lack of cuts suggested in the report and publicly denounced it. The chair of the 2000 committee that called for the study, State Senator Robert Lee, commented after the release of the report, "Frankly, $4 to $6 million every year does not even touch the problem," Lee told the Idaho Statesman in Boise. "I don't think we're getting a $600,000 effort. I'm upset about that, and I'm being very frank."[33]

Additionally, in January 2000, the Lewin report conducted a comparison of Idaho's Medicaid program with other neighboring states. This evaluation was again done at the request of JFAC in hopes of discovering more cost-saving strategies to respond to the high administrative costs. This report compared Idaho's Medicaid statistics with those of neighboring states and found that Idaho eligibility levels and covered optional benefits were competitive with surrounding states.

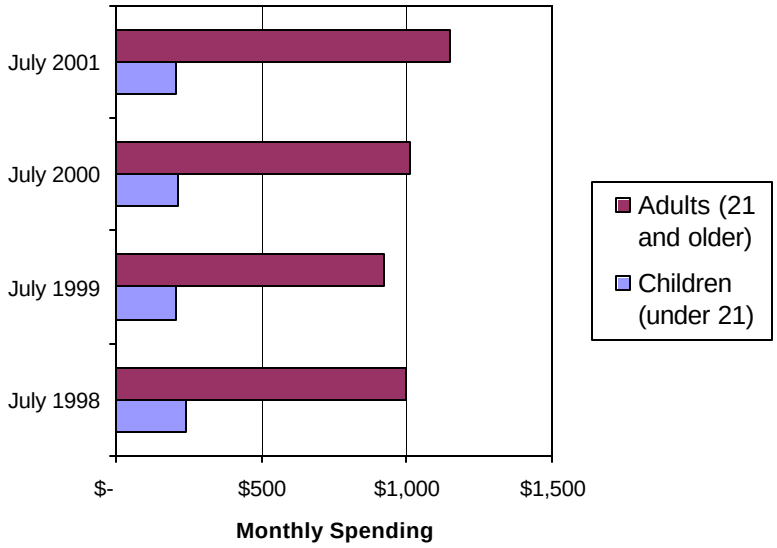
Despite the Lewin analysis, legislators seemed to accept the analysis from the Governor's Office of Financial Management and Legislative Services that children applying for the Children's Health Insurance Program, and those children who were determined eligible for Medicaid rather than CHIP, were causing much of the problem. Idaho Legislative Services predicted that enrollment in the Medicaid program would swell by 33 percent from 1999 to 2001 due to CHIP.[34] Legislative Services points to the higher number of children who have enrolled in CHIP and Medicaid as responsible "much of [the Medicaid] shortfall."[35]

Children's Health Insurance Program shoulders the blame, but actually costs very little

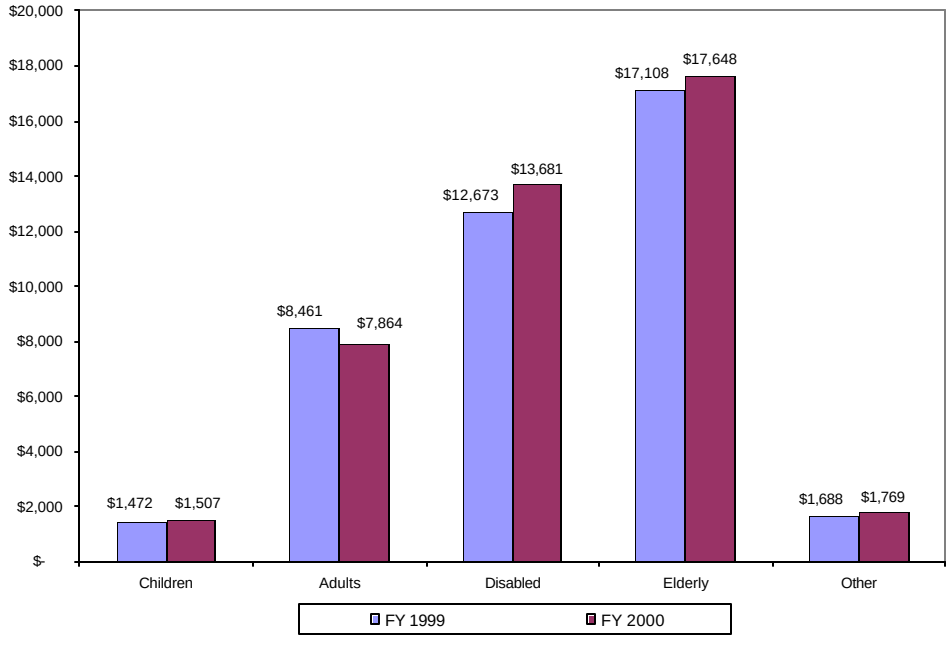
While legislators were publicly focusing on the Children's Health Insurance Program as responsible for driving up program costs by increasing children's enrollment in the Medicaid program, very little attention was paid to the actual cost of covering these children. While children's enrollment in Medicaid has increased by 40 percent (from 57,000 to 94,329) since outreach for CHIP began in late 1999,[36] these children cost the state only $300 a year for those on CHIP and $450 a year for those on Medicaid.[37] The difference in cost to the state is primarily due to the higher match rate for CHIP (80 percent) compared to the lower Medicaid match rate (71 percent). Compared to other Medicaid enrollees, children are the least expensive group to cover.

In addition, according to the U.S. Census Bureau, there was an average of 53,000 uninsured children at or below 200 percent of the federal poverty line from 1997 to 1999. Many of these children have likely enrolled in Medicaid or CHIP and currently Medicaid covers children only up to 150 percent of the federal poverty line. The phenomenal growth rate cannot continue because Idaho will run out of eligible children.

Combined state/federal dollars spent per month by age of enrollee[38]



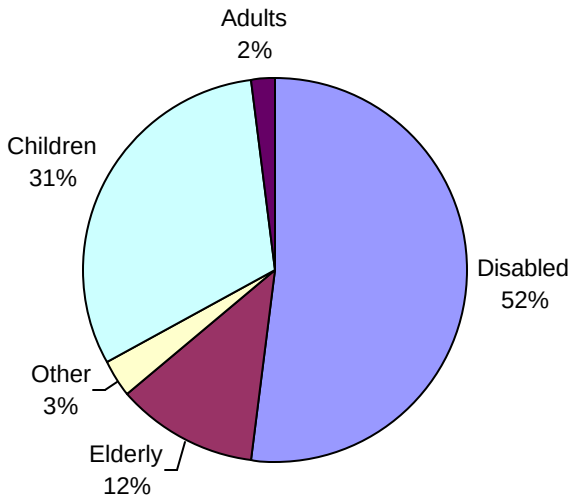
Changes in Idaho Medicaid Federal/State Combined Annual Spending Per Enrollee, 1999 and 2000



Major sources of cost increases have received little attention

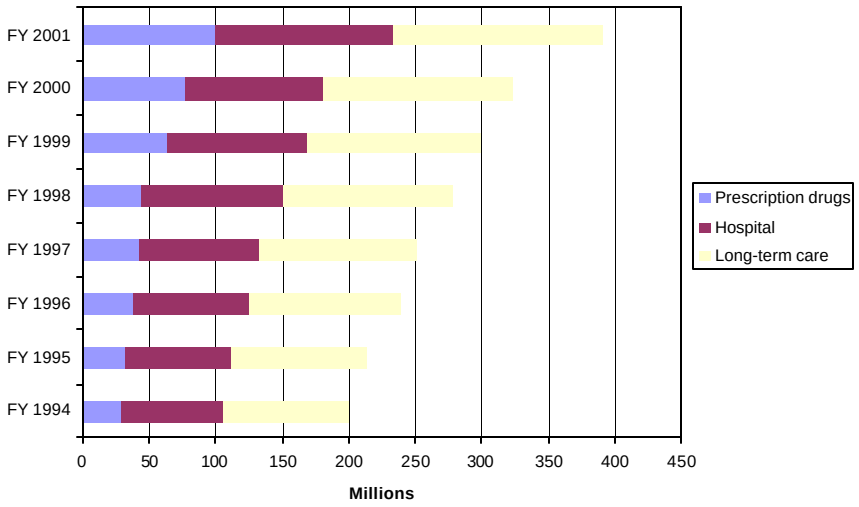
The Medicaid enrollment groups that are facing increased costs are groups that will likely grow in the coming years due do Idaho's aging population. The elderly are more likely to become disabled and need more expensive medical services than other populations.

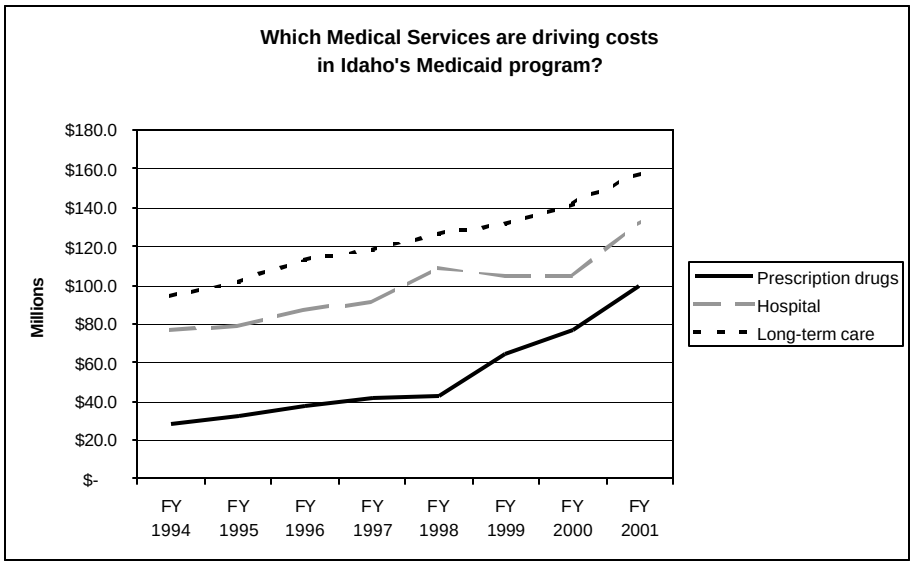
Medicaid Spending Spending Growth in Idaho from FY 1999 to FY 2000 by Beneficiary Category



The largest cost-drivers in the Medicaid program, long-term care spending, hospital services, and prescription drugs were not part of the public debate on what was driving Medicaid costs.

Main cost-drivers in Idaho's Medicaid Program, 1994 to 2001[39]





Long-term care spending

Medicaid spending on long-term care has increased by 25 percent between FY 1997 and FY 2001. Long-term care includes a wide array of care settings and services for people with disabilities, most of whom are elderly. Services include not only institutional care provided by nursing homes but also home and community-based care. Long-term care is already the largest component of Idaho's Medicaid budget.[40] The cost of providing services to the existing disabled enrollees is expected to grow 2.8 percent a year, the highest cost growth rate of any group of Medicaid enrollees.[41] If national projections hold true for Idaho, Idaho's long-term spending will increase by 31 percent over the next decade and by 68 percent between 2000 and 2020.[42]

Because Idaho's population, like the nations, is aging and people are living longer, there will be more of a need for long-term care services in the future. Baby boomers will begin to reach age 65 in 2011, swelling the ranks of the elderly.[43] In 2000, individuals aged 65 or older made up 12.7 percent of our nation's total population. By 2020, that percentage will increase by nearly one-third to 16.5 percent – one in six Americans.[44] Because few other coverage options are available or affordable for long- term care, Medicaid will continue to be the largest funding source for these services.[45]

Hospital spending

Idaho's Medicaid spending on hospital services has increased 32 percent in the past five years. The American Hospital Association says hospitals are faced with higher costs for prescription drugs, escalated costs for new blood screening techniques, and other higher costs for services -- and that they must increase their prices in order to continue caring for their patients.[46] Because prescription drug prices are projected to continue to increase, hospital costs will continue to increase as well.

Prescription Drugs

Medicaid spending on prescription drugs has increased by an astonishing 43 percent during the last five years and spending is expected to continue to increase for the foreseeable future. Prescription drugs are increasingly becoming the treatment of choice for almost all types of health problems. Since Medicare does not provide prescription drug coverage, the increasing costs of prescription drugs falls heavily on Medicaid. The federal government projects that prescription drug expenditures will rise about 70 percent faster than overall Medicaid expenditures between 2001 and 2006.[47] The increased cost of prescription drugs will particularly impact Idaho's budget, since Idaho already spends more of its Medicaid budget on pharmaceuticals than its peer states (Montana, Wyoming, North Dakota, and South Dakota).[48]

V. How legislators attempted to contain costs during 2000 and 2001:

Despite budget surplus in Idaho for the past few years, the Legislature's concern for rising Medicaid spending continues to escalate. The Governor, the Legislature and the Department of Health and Welfare have spent these past years analyzing program changes in Medicaid that could save the state money. With the recent passage of Senate Bill 1274, the Idaho Legislature has taken some immediate steps to limit the expansion and services provided by the Medicaid program. The Legislature also required studies by the Department to provide utilization management and cost-sharing measures to curb costs and limit use of Medicaid services. Much of this was done after the release of the Lewin report.

Senate Bill 1274 was introduced before the Idaho State Senate on March 29, 2001 and signed into law by the Governor on April 9, 2001. This bill was drafted late in the session in a majority caucus, behind closed doors, and with no public input. This bill was apparently introduced to curb escalating costs of implementing the Medicaid program in Idaho. The legislation included recommendations made by the Lewin report as well as measures to cut costs not originally identified by the Department of Health and Welfare. The bill also approved a supplemental appropriation, which included $33 million in state general fund money for unpaid Medicaid bills.

Capping coverage for Children

Of the many provisions of SB 1274, among the most controversial was Section 5, aimed at limiting Idaho's recent successful attempts to insure Idaho's children. Since 1997, Idaho's efforts to expand its Medicaid program have not only located children eligible for the new CHIP-funded program, but has also identified children eligible for basic Medicaid. In the floor debate for SB 1274, lawmakers noted that enrollment efforts have been "too successful" and that employers were encouraging crowd out, and increased Medicaid enrollment is "something they want stopped."[49]

The Idaho Legislature has capped spending of Title XXI CHIP money at $4,600,000 for FY 2001. The Department of Health and Welfare was authorized to lower or raise the income eligibility requirements in an attempt to stay within the budget of $4,600,000. Under this

provision of SB 1274, once the $4,600,000 has been used, the state would no longer provide insurance to optional targeted low-income children.

As of November 1, Idaho covered about 13,000 children with its CHIP program. If Idaho continues to spend at a rate of about $300 state dollars per CHIP child per year, it can cover about 15,000 children in its CHIP program with the $4.6 million in state funds.[50] Despite the elimination of the outreach program on July 1, 2001 (discussed further below), Idaho continues to enroll children at a steady pace. If the enrollment rate between July 1, 2001 and November 1, 2001 continues through 2002, Idaho will enroll more than 15,000 children by November 2001.

Because Idaho did not begin enrolling a significant number of children in its CHIP program until 1999 and has never spent its full federal CHIP allotment each year, Idaho has a significant amount of unspent CHIP funds from fiscal years 1998 to 2001. Congress reallocated about 35 percent of the 1998 unspent funds to the 12 states that used all of the 1998 federal allocation. With this reallocation considered, Idaho still has more than $35 million in unspent funds.[51] However, Idaho cannot access its federal CHIP allocation from previous years unless it provides the needed state match of about $7 million. With CHIP enrollment levels reaching the maximum levels allowed by the $4.6 million state funds cap, it is not clear how Idaho will be able to access these unspent funds. If Idaho does not access them, they revert to the U.S. Treasury or will be reallocated to other states by Congress.

According to officials at HCFA, nothing in the CHIP regulations prevents a state from capping its budget.[52] Under Title XXI, Idaho must contribute payments equal to seven-tenths of what it would be required to contribute under Medicaid. For example, in 1998 Idaho was allocated a total of $15,959,159 in enhanced federal funding. If Idaho used the total amount allocated, it was required to match $4,316,739 in state funding for that year. Idaho's cap of state funding at $4,600,000 appears to be its estimated state match funding for enhanced FMAP for FY 2002.

Medicaid is an entitlement program; therefore if Idaho chooses to insure a child at a certain income level, it is required to insure all children at that income level. Unless the state has already amended the State Plan to eliminate the optional targeted low-income group, it is obligated to provide services to eligible children. For example, if Idaho's eligibility to optional targeted low-income children remains at 150 percent of the Federal Poverty Line (FPL), it is required to provide Medicaid to all children who meet that requirement. Even if the state budget reaches its cap, unless the State has amended its State Plan to reduce the FPL below 150 percent, it still must provide insurance to all children at 150 percent who are currently enrolled or who are applying to enroll. Therefore, if Idaho refuses to match any federal funding due to limitations on the state budget, it would need to lower eligibility rates and terminate Medicaid for every child that is above the new FPL rate. Idaho does not need to submit a State Plan amendment as a result of the enactment of SB 1274, however, as soon as it becomes necessary to modify eligibility requirements for SCHIP to comply with SB 1274, a plan must be submitted.

Under the original guidelines for Title XXI, a state may amend its plan to drop an optional targeted low-income group but it is required to submit the amended plan to CMS before the change goes into effect. The U.S. Department of Health and Human Services will notify the state within 90 days if the amendment is not approved.

Outreach Efforts Halted

In March 2001, DHHS approved a waiver submitted by Idaho's Department of Health and Welfare for CHIP to increase enrollment by 4,000 and expand outreach.[54] The Health Care Financing Administration (now CMS) sent out a press release on March 5, 2001 where Secretary Tommy Thompson stated, "Idaho's expansion demonstrates how popular this program is with states and how vital it has proven to be for the families enrolled."[55] Just weeks later the Legislature introduced this legislation to cap CHIP enrollment and end almost all outreach practices.

During the 2000 fiscal year, 17,184 children enrolled in Medicaid as a result of the SCHIP enrollment effort.[56] For every five new enrollees, four enroll in Medicaid and one in SCHIP funded Medicaid.[57] With this success comes additional strains on the state budget to match the federal funding provided to insure these children, although at the same time children are one of the least expensive Medicaid populations to insure. Despite the great benefits of offering insurance coverage to children, this new law appears to be an attempt to severely limit outreach to the additional eligible uninsured children and terminate state funding for optional targeted low-income children once the CHIP match has been exhausted.

Every state that accepts CHIP funding is required to engage in some type of outreach to educate families, assist them in enrolling children in the appropriate program, and coordinate health insurance programs across the state. Medicaid will match states' expenditures associated with outreach to Medicaid eligible children or the state can use CHIP to pay for outreach for CHIP eligible children at the enhanced CHIP matching rate (up to the 10 percent limit).[58] A state must submit its outreach plan to HCFA for approval.

After pressure from community groups and advocates, DHW began an aggressive outreach campaign in late 1999. It used funds from its federal welfare block grant for advertising through June 2001 and partnered with other organizations to get the word out about CHIP.[60] DHW also ran television and radio public service announcements about the CHIP program.

Due to the prohibition in SB 1274 on outreach beyond "federal requirements," the DHW has pulled its TV and radio public services announcements and canceled its contacts with community organizations such as Head Start and Girl Scouts of America.[61] Since HCFA has no mandatory standards to determine if an outreach plan is adequate, this could mean that an acceptable outreach program would simply include a brochure about the Medicaid expansion in statewide locations.[62] Currently the Director of DHW is meeting with the chairs of the finance committee in the Legislature to further clarify the ramifications of the intent language of this new law. This prohibition apparently does not include outreach regarding immunization, which is notable as Idaho ranks last in the nation for proper immunization of children.

Idaho has spent over $633,000 of federal funds since 1999 on outreach for SCHIP. This money, along with other community and grant money such as the $26 million given to Boise Idaho for a back-to-school outreach campaign, increased enrollment in both the Medicaid and SCHIP program. In just one year, enrollment nearly doubled to 10,000 children in the SCHIP program.

The outreach efforts for CHIP also greatly increased enrollment in the Medicaid program. Despite the growing numbers of children served in the Medicaid program, children are the least expensive group to cover under Medicaid. In 1998, children made up 58 percent of the total enrollment for Medicaid in Idaho, but children only accounted for 15 percent of spending for enrollment groups.[63] However, the legislators cut the outreach program that targeted the least expensive population to cover.

Managing care for those with developmental disabilities or mental health illnesses:

One specific area of growth is spending on individuals with developmental disabilities and/or mental health illnesses. Because spending on this category of individuals grew 50 percent between 1994 and 1999, the Department of Health and Welfare has begun designing a Utilization Management Program (UMP) to manage costs for medical care to these groups of individuals. The UMP is a program that will require prior authorization and review of services for people with developmental disabilities and/or mental illness. In an informational page posted online by the Department of Health and Welfare, UMP promises to "assure that everyone involved focuses, first and foremost, on the best possible outcome for the consumer."[64]

Freezing reimbursement rates

SB1274 requires all reimbursement rates in Medicaid, including rates for intermediate care facilities, to not exceed the rates covered in 2000 and the rates for all durable medical equipment for 2001- 2002 to not exceed the rates paid in 2001. This could further reduce provider participation in the state's Medicaid program and make it difficult to obtain adequate equipment for those with disabilities.

Exploring Cost-Sharing

Cost-sharing occurs when Medicaid enrollees are asked to share in paying for their health care coverage in the form of deductibles, co-payments, or premiums. Medicaid protections stipulate that enrollees cannot be required to pay more than a "nominal" amount as their share of the costs for care. Since Idaho's CHIP program is an expansion of the state's Medicaid program, Medicaid cost-sharing rules apply to the children covered by CHIP, not the cost-sharing provisions in the CHIP legislation. Separate state CHIP programs allow enrollees to be charged as mush as five percent of a family's annual income for cost-sharing. However, the cost-sharing protections in the Medicaid program are currently at risk due to HHS Secretary Tommy Thompson new state Medicaid waiver policy.

Currently, Idaho imposes few cost-sharing requirements for most individuals enrolled in Medicaid. For Idaho to run a cost-sharing program, it will need to add to the currently high administrative costs to implement procedures for notification, billing, and non-payment. There is also the danger of imposing cost-sharing on individuals who cannot afford to share in the payment for care, and will likely delay or forgo care altogether. But high premiums can negatively affect Medicaid participation, and even modest increases in premium costs decrease participation.[65]

Despite the disputed success of cost-sharing practices, the Idaho Legislature made many attempts to impose some cost-sharing strategies to Medicaid beneficiaries. Legislation, such as HB 1, was introduced to allow the DHW to begin implementing cost-sharing practices for Medicare. The attempt received great public outcry, and eventually the bill was killed. The Legislature did not give up on imposing cost-sharing, and instead passed legislation through the process that does not require public input, the Joint Finance Appropriate Committee (JFAC). This legislation, SB 1274, had a provision that will allow the department to use waivers and existing law to implement co-pays and cost-sharing among beneficiaries.

Shifting costs to the federal government

Idaho will also attempt to alleviate pressure on the state budget by leveraging federal dollars to convert the state's veteran hospitals to Medicaid certified facilities and in turn reduce state spending on the patients in these facilities. The Legislature and DHW began an initiative to certify state run veterans facilities. The result of this conversion should be an increase in revenue of $1.6 million, coming from federal reimbursement dollars for providing care. Although veterans may receive increased levels of care, and better patient staff ratio, many veterans may not qualify as Medicaid recipients and therefore will see out of pocket costs increase. The Lewin Group report estimates that 40 percent of the veterans currently living in these homes may be affected financially by the conversion.[66]

Exploring the high cost of prescription drugs:

The Idaho Legislature, like every state, is concerned with the rising costs of prescription drug prices. The growth rate for prices is twice the rate of inflation and the pharmaceutical industry remains the most profitable industry in the country. The great expense of prescription drugs hurts the state's ability to control the Medicaid program costs. The prescription drug benefit to Medicaid beneficiaries is a vital benefit, however, the costs of providing this benefit creates unmanageable budget spending which affect the success of the Medicaid program.

The legislature made a limited attempt to address the rising cost of prescription drugs in the Medicaid program, and most of the changes are focused on controlling what type of drug an individual beneficiary may receive or what type of cost-sharing a beneficiary will endure. Medicaid beneficiaries will be required to use generic drugs whenever possible and require prior approval with the DHW before a physician prescribes a non-generic drug. The Legislature required the DHW to prepare a report addressing the feasibility of a drug formulary for the Medicaid program. Additionally, the Legislature required the DHW to review the use of waivers or existing law to pass some of the costs of prescription drugs to the beneficiary in the form of a co-payment.

Idaho took no action to address the extremely high reimbursement rates for pharmacists or the high costs that the drug manufacturers charge for their product. The Lewin Group report suggested that the Idaho Legislature could save at least $200,000 by reducing reimbursement rates and the rates pharmacists receive each time they fill an order. The Lewin report found that reducing pharmacists' rates could save Idaho over $150,000 a year if the rate was cut by $.50 for

each prescription filled. Currently, Idaho pays pharmacists $4.94 for every prescription filled, compared to the $2.50 paid by private insurers for each prescription filled in Idaho.

Idaho law requires that the Legislature negotiate any changes in price with the pharmaceutical industry before any reduction in price is implemented. The Lewin report notes that Idaho already pays too much for prescription drugs for the Medicaid program. The report suggests a saving of $37,500 to $112,5000 annually if Idaho focused on negotiating better prices with the pharmaceutical industry. The Legislature passed a bill seeking to negotiate better deals with the pharmaceutical industry to buy in bulk in partnership with neighboring states.[67] Although the idea of combining forces to negotiate better prices with Washington, Oregon, Alaska and Montana have been discussed among leaders from these states, and Washington passed a bill similar to Idaho's, negotiation has not begun.

While many states are seeking federal support for capping prescription drug prices to more affordable levels, Idaho has a few options it can explore to begin controlling escalating prescription drug prices. Controlling costs for the program should include strategies that address the root of escalating costs. Unfortunately, controlling prescription drug prices seems to get less attention from the Legislature and instead the success of the CHIP program, which has enrolled large numbers of new children in the program who are the least expensive population to cover, is targeted for dramatic cuts.

Other benefits limited

Idaho removed state money for health-related abortions for low-income women, although this issue is pending in federal court. The Legislature also limited the number of beds covered by Medicaid in private intermediate care facilities for the mentally retared. Only 486 beds will be funded to serve the mentally retarded enrolled in the Medicaid program. Any additional beds planned or under construction will not be funded by Medicaid. It is unclear if this is a permissible action in Medicaid.

Area not addressed by the Legislature: Physician Provider rates

Under section 1396 (a)(30) of the Social Security Act, the federal government requires that reimbursement rates for public programs must be set at a level that assures the payments for care are high enough to provide access to medical care for those in the program. The payment levels must be high enough to assure access equal to the general population in the same geographic area.[68] Despite this, doctors consider reimbursement rates in Idaho to be low (although they are the 9th highest in the nation) and many doctors will not take new Medicaid patients, particularly those in the rural areas.[69] As fewer and fewer doctors participate in Idaho's Medicaid program, a low-income person that has Medicaid coverage, like the uninsured, may still be forced to use the emergency room as their main source of care.

Other Anticipated Cost-Containment methods in Medicaid Program

Idaho has used several strategies to increase the funds it receives from the federal government. In the 1980's and early 1990's, states made payments to Disproportionate Share Hospitals (DSH),

received federal matching Medicaid dollars, and then had the DSHs give that money back to the states. Although some of this money was used for health care, some of it went directly into a states budget for general use. The federal government has subsequently passed laws to limit this practice. Now, many states are engaging in a practice known as "upper payment limit" (UPL) arrangements or the "Medicaid loophole." In this situation, states make inflated payments to nursing homes, hospitals, and other health care facilities. It has been estimated that these UPL arrangements have risen from $313 million in 1995 to $1.4 billion in 1998.[70] These facilities then receive the federal matching funds and give the excess from the inflated price of care back to the state. The federal government passed a rule that will attempt to phase out this practice within the next eight years. It is hard to determine whether a state is using these practices to increase their budgets, however, Idaho has apparently requested approval from HCFA to take advantage of the UPL arrangement before it is entirely phased out.

VII. The Future of Medicaid in Idaho

At a time when advocates for children and health care are urging Idaho to increase the eligibility of children for Medicaid to 200 percent of the FPL, Idaho has chosen to limit the expansion of Medicaid to needy children. One in Idahoans is still without health insurance. In the long run, these individuals will end up costing the state more money by using more emergency services or suffer from serious illnesses that may have been treatable or preventable if they had access to health insurance.

The Idaho Legislature has not made public health care coverage expansion a priority. Although the state has one of the highest Federal Matching Assistance Percentages and it had a budget surplus in the past two years, the spending increase for Medicaid programs generated great concern with the Idaho Legislature. This year, the Legislature took measures to cap spending on Medicaid and enroll fewer beneficiaries. The number of uninsured in Idaho remains at a high level, with over 16 percent lacking health care coverage.[71] Unless the government decides that health care coverage is a priority – funding for services will continue to be threatened.

Another area that may allow Idaho to cut costs by denying services could be decided in the courts. The recent case in Michigan that may determine whether a state may be sued by the federal government for not following the federally mandated guidelines for accepting Medicaid funding may play a role in determining a case before the courts in Idaho. Former Idaho State Supreme Court Justice Huntley filed lawsuit against the state in federal court charging that the state does not test children for lead poisoning, even though this is a mandated service in the Medicaid program. Governor Kempthorne is named in the suit for not providing funding and manpower to meet the 80 percent of Medicaid children tested for lead poisoning goal. Idaho tests less than 1 percent of Medicaid population for lead poisoning.[72]

As the new administration in Washington allows states to increase the use of waivers to bypass federal mandates for the Medicaid program, it is likely that Idaho will use this system to save costs in its Medicaid program. This year Idaho took measures to limit spending on optional benefits that the state regulates. The waiver system is more relaxed. Through the federal Department of Health and Human Services, states will use the federal matching dollars whether or not states are administering the Medicaid program within the federal mandates. The Idaho

Legislature approved intent language to look into ways to curtail costs through the use of federal waivers. This practice will likely continue in a state that focuses more of its energy on saving Medicaid costs than covering the uninsured.

VIII. Conclusion

The cost of providing health care coverage to those who have no other affordable means to obtain coverage has been of great concern to the Legislature and Governor in Idaho. Individuals who do not receive employer-based coverage, but whose wages are too high to receive Medicaid coverage, often are left with no way to access medical care. Most Idahoans believe that individuals should have access to health care, especially children. In the past few years, the government has taken advantage of new programs, such as CHIP, to provide more coverage to those in need of health care.

During the period of Medicaid expansion for children, all costs in Medicaid grew rapidly, particularly the costs of covering the disabled and the cost of prescription drugs. This increased spending for Medicaid alarmed the Legislature. The Legislature acted during the 2001 legislative session to make cuts in the Medicaid, but they focused their cuts on the Children's Health Insurance Program, one of the least expensive components of Medicaid. The Legislature halted outreach and capped enrollment in the CHIP program. The real controllable cost drivers of the program, such as pharmaceuticals, were not addressed in any significant way. The failure of the Legislature to address real cost drivers will mean costs will continue to increase and children will have less access to health care.

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