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Testimony of

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**Strategies for Strengthening American's Vital Safety Net"**

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Chairman Grassley, Senator Baucus, and Members of the Committee, I thank you for the opportunity to appear before you today to discuss the future of Medicaid. This debate is timely, as both state and Federal officials are focused on Medicaid costs. My testimony, after reviewing Medicaid's goals, describes what factors drive Medicaid's costs and what to do about them. It also discusses the need for broader reform, since Medicaid's problems are the system's problems. Addressing only Medicaid will not prevent a further erosion in private coverage, and stabilizing private coverage will not reduce Medicaid's coverage and financing deficits. Finally, having this debate in the context of a restrictive budget resolution, with politics pushing against policies such as lowering drugs prices, could result in reduced coverage, not costs. This would not only weaken access to care for vulnerable populations but could exacerbate the nation's health financing crisis.

The ideas included in this testimony are drawn from two initiatives of the Center for American Progress. First, on June 8, we released three papers on cost drivers in Medicaid in an effort to inform the current discussion; ideas and direct passages from those reports are included in this testimony.[1] Second, we proposed a plan to improve and expand health coverage for all in the U.S., hoping to reignite the debate over systemic reform.[2] The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We aim to serve as a resource for policy makers on current topics, and welcome additional requests for information. All opinions expressed in this testimony are my own.

**Overview: Medicaid's Mission**

Today's debate is primarily driven by concerns over cost, but it is useful to review the program's goals to put the policy options into context. The first sentence of Title XIX, which governs Medicaid, essentially guarantees assistance to families, persons with disabilities and seniors whose income and resources are insufficient to meet the costs of necessary medical services.[3] Three often-overlooked points about this goal are:

- Medicaid is primarily focused on vulnerable populations; although states can use options and the State Children's Health Insurance Program to expand coverage to low-income working populations, such expansions are not its primary purpose;

- Medicaid is designed to remove financial barriers to care, which can take the form of uncovered benefits or cost sharing that is prohibitively high; and

- Medicaid is a guarantee; because its costs follow need rather than a budget, Medicaid spending unexpectedly dropped then increased in the last decade mirroring the economic swings; Federal funding increased in New York after 9-11 to fund Disaster Relief Medicaid; and its funding is shifting to rural areas where the aging of America has begun.

Because of this mission, Medicaid faces challenges other than costs: millions of poor people are either ineligible or not enrolled in the program; some who are enrolled continue to have access problems due to low provider participation or limited benefits;

and the quality of care could be improved, especially in long-term care.[4] Medicaid also has strengths that often go unnoticed. It contributes to reduced racial disparities; improved birth outcomes; higher educational attainment among children; and greater independence among persons with disabilities.[5] Thus, Medicaid reform should aim to improve quality, access, and innovation as well as program efficiency.

## What's Driving Medicaid Costs

While Medicaid costs can be assessed in a number of different ways, we at the Center for American Progress chose to focus on four cost drivers. The first and second are the service categories that rank the highest in their current and future potential cost growth: prescription drugs and long-term care. Third, we worked backwards: identifying those individuals responsible for most Medicaid spending to understand how and why they are costly. Fourth, we examine the pressures put on Medicaid by a deteriorating coverage system in the U.S. The facts plus possible policy options are described below.

### *Prescription Drugs*

When compared to other health insurance programs, Medicaid has both low spending per capita and low per-capita growth, especially when adjusted for the sickness of its beneficiaries. A study that adjusted for the different health profiles of enrollees found that Medicaid's costs are lower than those of private insurers, making it the preferred way to expand coverage to low-income populations.[6] A different study found that the annual rate of growth per enrollee in Medicaid between 2000 and 2003 was 6.1 percent, lower than the comparable Medicare spending growth per beneficiary and spending growth per privately insured person.[7] Medicaid has higher managed care penetration than Medicare, and lower administrative costs than private insurance programs.[8]

However, one service that continues to drive Medicaid costs is prescription drugs. Medicaid expenditures on prescription drugs doubled between 1998 and 2002, increasing from 8 to 11 percent of total Medicaid expenditures.[9] While Medicaid drug spending growth is projected to decelerate to 7.1 percent in CY 2004 – largely due to state cost containment efforts, it is still higher than other services' growth.[10]

The Federal government has been largely absent as states have implemented policies to contain Medicaid drug costs. States and the Federal government jointly fund Medicaid, and therefore rising Medicaid prescription drug costs also have adverse fiscal consequences for the Federal budget. In recent years, the Centers for Medicare and Medicaid Services (CMS) has taken some steps to support states with their pharmacy cost containment activities. For example, CMS issued guidance to states supporting supplemental rebate programs and identifying selected best practices.[11] However, more could be done at the Federal level to assist states and promote efficiencies across the country. This background and most of the ideas below are directly drawn from a paper by Kathleen Gifford and Sandy Kramer that includes additional options as well; since passages from this paper are used, these authors should be cited as appropriate.[12]

**Provide Information and Assistance to States in Setting Drug Reimbursement.** Federal policy could assist states in becoming more prudent purchasers at the retail pharmacy level. States largely operate "in the dark" in setting drug cost reimbursement without access to the actual drug acquisition costs paid by pharmacies. States typically cover over 50,000 National Drug Codes – each with its own price that can change unpredictably. It is therefore a challenge to find adequate current information to set drug reimbursement rates at levels that fairly compensate pharmacies without overpaying them. Recent reports by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have highlighted the millions of dollars lost to states and the Federal government each year due to Medicaid overpricing.[13] Below are two of several options to provide states with better information to set retail pharmacy reimbursement policies.

- **Provide states with accurate and timely "Average Sales Prices" (ASPs) for Medicaid covered drugs.** The MMA required that, for drugs covered under Medicare Part B,[14] Medicare move to a reimbursement system based on ASP. "ASP" is the weighted average of all non-Federal sales from manufacturers to wholesalers (net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product), and is based on quarterly pricing data supplied to CMS by drug manufacturers. While some critics argue that the ASP does not accurately reflect a retail pharmacy's actual acquisition cost, the ASP is likely a better starting point for estimating that cost than the "Average Wholesale Price" (AWP). Note: since ASP is untested, there may be a better market-based measure of acquisition costs.

  President Bush's 2006 Federal budget proposal would require states to adopt an ASP plus 6 percent payment methodology (consistent with Medicare Part B) and estimates Federal savings of $542 million in 2006 and $5.4 billion over five years. Moving to an ASP methodology in Medicaid, however, would be a significant and costly undertaking that would be difficult for states to accomplish on their own. To enable all states to benefit from this methodology, the Federal government, acting through CMS, should handle the data collection and timely pricing of the over 50,000 National Drug Codes commonly covered by state Medicaid programs. This is an expansion of its role since, currently, CMS collects manufacturer data on only 5,700 National Drug Codes to price 550 Part B drugs. States would also need CMS to provide timely pricing information on new drugs entering the market and for manufacturer price adjustments that occur from time to time (currently, CMS provides only quarterly updates for Part B drugs subject to ASP pricing). Ultimately, the benefit to states of moving to an ASP methodology would depend heavily upon the effectiveness of CMS in calculating and reporting the ASP prices. Lastly, states should retain flexibility on how to use ASP in their reimbursement; it may be that ASP plus 6 percent results in overpayments, may not appropriately pay pharmacists, and provides incentives to prescribe high-cost drugs.

- **Change Federal law to allow the release of AMP information to the states.** The "Average Manufacturer Price" (AMP) data provided to CMS by drug manufacturers to support the Medicaid Drug Rebate Program may be the most accurate drug pricing

data currently available to CMS for non-Medicare Part B drugs. A limited disclosure of these data to states could be required by Federal law to help states set drug cost reimbursement at appropriate levels, as has been recommended by the OIG.[15]

**Maximize Manufacturer Rebates.** The methodology for the required rebate that drug manufacturers must pay to participate in Medicaid has not been modified for over 12 years, despite rapid growth in costs. This has forced a growing number of states to seek supplemental rebates, which can sometimes be difficult for a state to enact. The following proposals describe Federal policy changes to the current rebate formula that would increase rebate revenues.

- **Increase the minimum Federally-required rebate.** Some states do not have the size or circumstances to negotiate supplemental rebates. Moreover, when the new Medicare prescription drug benefit is implemented in 2006, direct Medicaid drug expenditures will be cut in half. The lost prescription volume will likely decrease the market leverage that states have to negotiate supplemental rebates. An updated brand-drug minimum rebate would help states compensate for the loss of market leverage and ensure that all states, as well as the Federal government, pay a fair price for prescription drugs covered by Medicaid. The National Governors Association, on a bipartisan basis, supports increasing the rebate.[16]

- **Implement systematic oversight of self-reported manufacturer pricing data to ensure the accuracy of Medicaid drug rebates.** Currently, the calculation of Medicaid drug rebates relies upon self-reported AMP and "best price" data supplied to CMS by drug manufacturers. In recent years, a number of drug manufacturers have agreed to pay millions of dollars in legal settlements to resolve allegations involving the underpayment of Medicaid rebates arising from the failure to properly report best price.[17] A recent report from the Government Accountability Office (GAO) also found that current rebate program oversight by CMS does not assure that manufacturer-reported drug prices are consistent with applicable laws and program policies.[18] Consistent with GAO recommendations, CMS should implement a plan to systematically scrutinize AMP and best price data reported by manufacturers to enforce the accurate payment of Medicaid drug rebates to states.

**Promote Evidence-Based Coverage for Drugs.** In the long-run, research on what drugs work better and/or cost less than other will be key to improving outcomes and efficiency. After four years of widespread, continuous efforts to cut Medicaid drug spending growth, a consortium of 15 organizations, including 13 states, has formed to create the Drug Effectiveness Review Project (DERP) whose purpose is to carry out systematic reviews of drug classes to inform state drug coverage decisions, usually in connection with a state's Medicaid preferred drug list (PDL). These systematic reviews, conducted by Evidence-Based Practice Centers (mostly university-based), array, evaluate and summarize the aggregate results of published and unpublished studies pertaining to the drug class under review. By May 2005, the DERP had completed 18 reviews and states were using its information as the primary or one of many sources in setting their PDLs.[19]

- **Greater Federal leadership and funding for comparative effectiveness research.** Medicaid along with its beneficiaries would benefit from an expansion in the base of evidence-based research. Information on comparative effectiveness will allow states to define "smart" PDLs rather than rely too heavily on price considerations when making PDL coverage policies. This could take the form of full funding of the existing authority to fund such research. Section 1013 of the MMA requires the HHS secretary to set priorities and target areas where evidence is needed to improve the quality, effectiveness and efficiency of health care provided by Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). While the MMA authorized $50 million in FY 2004 to carry out Section 1013, only $15 million was actually budgeted for this effort in 2005 and the President's 2006 budget maintains funding at the $15 million level. At a minimum, funding to carry out Section 1013 should be increased to the amount authorized by the MMA. However, the Center for American Progress's health plan calls for not only a substantial increase in the Federal investment in this type of research but consideration of creating a quasi-governmental agency to set the agenda, gather private as well as public resources, and conduct research on a range of health services.

**Address Costs and Transitions in the Medicare Drug Benefit.** In the short run, the issue most pressing for states regarding drug costs may be the implementation on the Medicare drug benefit. On January 1, 2006, Medicare will assume primary coverage for prescription drugs for Medicaid beneficiaries also eligible for Medicare (known as "dual eligibles"). Why this may increase state Medicaid drug costs and options for preventing this are described below.

- **Effective Medicare cost containment to reduce state Clawback payments.** When the Medicare prescription drug benefit takes effect in January 2006, state Medicaid programs will no longer provide drug coverage for dual eligibles, but will continue to help finance a substantial portion of the new Medicare drug coverage through the "Clawback", a type of maintenance of effort payment. The Clawback formula includes future annual adjustments based upon per capita spending growth for the Medicare drug benefit.[20] Thus, states have a direct interest in how the Medicare drug program is managed: higher per capita growth in Medicare drug spending means a larger Clawback obligation for states.

  Section 1860D-11(i) of the Social Security Act, as added by the MMA, bars the secretary of HHS from interfering with the negotiations between drug manufacturers and pharmacies and sponsors of prescription drug plans, or from requiring a particular formulary or price structure for covered Part D drugs. The Congressional Budget Office (CBO) has estimated that there would be negligible savings if this provision was struck,[21] but others disagree. They point to the substantial discounts obtained by other countries who negotiate on behalf of their citizens and by the U.S. Veteran's Administration as compelling evidence of the savings potential for Medicare.[22] Even if HHS chose not to exercise its authority to negotiate for better prices (or exercised its authority poorly), the repeal of Section 1860D-11(i) may, nevertheless, promote better drug pricing for Medicare by changing the context in which drug pricing

decisions are made – pharmaceutical manufacturers may be more likely to exercise restraint in their pricing decisions to avoid provoking a response from HHS.

- **Transition.** On January 1, 2006, Medicare will become the primary payer for drug coverage for dual eligibles, and Federal matching payments through Medicaid for such individuals will end. This transition will involve: extensive education about the change in the nature of the drug coverage; major data matching activity to ensure that no beneficiary falls through the cracks in the transition; assistance for dual eligibles in selecting a private insurance plan and recognizing that they will be default enrolled into a plan if they do not actively select one; and, once enrolled, ensuring an understanding of how a closed formulary works and how to access drugs not on that formulary.[23] The experience of de-linking Medicaid from welfare resulted in significant transition problems in some areas.[24] Last week, concerns were raised by reports of thousands of low-income seniors receiving empty envelopes rather than information on the transition to the Medicare drug benefit.[25] State Medicaid directors themselves have raised major concerns over their ability to carry out this major transition in such a short time window.[26] Because there is no back-stop or "emergency break" in case problems do occur, Congress should consider legislation such as that proposed by Senator Rockefeller (S 566) and Representative Allen (HR 1144) to allow Federal Medicaid funds to continue during the transition.

***Long-Term Care***

As the nation ages, the growing need for long-term care will strain health and retirement security as well as the Federal budget. A paper by Judy Feder outlines the problems and potential options; since passages from this paper are used, her paper should be cited appropriately.[27] Today, 10 million people of all ages are estimated to need long-term care. Among the roughly 8 million who are in community settings, 1 in 5 report getting insufficient care. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded $50,000, and of home care (four hours per day) was estimated at $26,000. Clearly, the need for extensive, paid long-term care constitutes a catastrophic expense. Intensive family care-giving also comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. As such, the answer appears to be long-term care insurance.

However, a vigorous private long-term care insurance market has not emerged. Sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s); about 6 million people are estimated to currently hold any type of private long-term care insurance. The demographic aging of America, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But, private insurance for long-term care remain a limited means to spreading long-term care risk. Private long-term care insurance: (1) is not affordable to the substantial segment of older persons with low and modest incomes; (2) limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and (3) lacks the premium stability and protection to prevent lapses in coverage and loss of the investment.

Public programs also fall far short of ensuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care (19% of total U.S. spending). Medicaid plays the primary role in financing the long-term care. In 2002, Medicaid paid for close to half of long-term care expenditures; despite the fact the vast majority of Medicaid beneficiaries are low-income adults and children not needing such services, long-term care accounted for about a third of Medicaid spending.[28] But, unlike what we think of as "insurance," Medicaid pays for services only if and when there are no other options. Because the cost of long-term care is so high relative to most people's income and resources, there is ample opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify. As Dr. Feder has put it, it is the "last remaining estate tax standing". Yet, most nursing home users who qualify for Medicaid have such limited resources that they satisfy Medicaid's income and asset eligibility requirements on admission. Only about 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted.

Despite Medicaid's essential role in financing long-term care, it has limitations. A large share of Medicaid's long-term care spending is for nursing home care, an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14 percent to 29 percent of Medicaid's total long-term care spending, but still is insufficient to meet the demand. Further, most states have expanded home- and community-based care through programs that "waive" some statutory Medicaid requirements, including the entitlement to service for people who qualify due to need for care. The ability of states to limit, through waivers, the number of people who can receive assistance leaves large numbers in need of assistance without service. And, Medicaid's protections vary considerably from state to state. An analysis by the Urban Institute found that, among 13 states, long-term care spending per aged, blind, or disabled enrollee was four times greater in the highest-cost relative to the lowest-cost states.[29]

A number of options exist to address long-term care problems generally and Medicaid specifically. Most experts, including Dr. Feder, suggest that the nation adopt a long-term care social insurance program, in which everybody contributes to financing the system and resources are allocated based on need. Among developed nations, the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing.[30] Two options short of this include:

- **Medicare Long-Term Care Partnership Program.**[31] Four states currently operate "Partnerships for Long-term Care" programs, which allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved long-term care insurance policies. These partnerships have been advocated as a means to save Medicaid money by encouraging people to purchase private long-term care insurance which could delay the need for Medicaid. Experience with these policies in four states has produced only limited purchases, primarily among higher-income people, and has affected too few people for too short a period to assess its

impact on Medicaid spending.[32] The Partnership Program has contributed to improved standards for long-term care insurance policies and more Partnership policies are being sold to more modest-income people as the standards that apply to them are also applied to the broader market. However, if these policies simply substitute for policies individuals would otherwise have purchased, they may increase rather than decrease Medicaid expenditures.

A better option might be to create such a partnership with Medicare rather than Medicaid. As a broadly-financed, social insurance program, Medicare may be the better program on which to build a long-term care insurance system. The proposed policy would give Medicare beneficiaries the option when they sign up for Medicare or Social Security retirement benefits of receiving an income-related Medicare long-term care catastrophic benefit if they simultaneously purchase a high-quality, private long-term care insurance policy. The Medicare catastrophic benefit would be available once private coverage is exhausted. This could be a new benefit, or financed by substituting the new catastrophic protection for the existing Medicare home health benefit, which would be covered by the private insurance policy. The goal is to refocus Medicare's limited long-term care investment to both encourage a better relationship between private and public coverage and protect beneficiaries from the catastrophic costs of chronic illness. In so doing, private long-term care insurance should become more affordable since Medicare would act as a reinsurer, limiting the liability of private insurers – to a greater extent for lower-income people -- and allowing them to offer better coverage (longer and higher quality) compared to existing products.

- **National, Federally-funded Medicaid home care benefit.** Federalizing home care for low-income people who need long-term care is a logical "next step" in long-term care financing. Creating the opportunity for individuals to receive long-term services and supports in the community—irrespective of where they live—would improve the quality of life for beneficiaries and for their family caregivers, even if eligibility levels remain relatively low. To achieve this goal, the Federal government could fully fund a "community support services" benefit for all individuals with income below a specified, nationwide eligibility level (similar to the fully-Federally funded income floor provided by Supplemental Security Income). States that wanted to expand enrollment above this level could do so. However, the new program would create a nationwide safety net to ensure a minimum level of protection for people in need.

### *High-Cost Cases*

While policy makers have focused on the size and growth of Medicaid spending, few have examined the beneficiaries who are responsible for most costs. Studies of high-cost enrollees have been conducted for Medicare and private insurance spending. Recently, CBO examined the role played by high-cost Medicare beneficiaries in Medicare spending. It found that Medicare spending is highly concentrated, with the highest-cost 10 percent of Medicare beneficiaries accounting for 61.5 percent of all Medicare

spending in 2001.[33] A similar study examined the distribution of spending among non-elderly people with some private employer-sponsored insurance. It found that the top 10 percent of cases accounted for 63 percent of expenditures.[34] In a paper by Andy Schneider, Yvette Shenouda and me, we found even more concentrated spending in Medicaid (passages from this paper are below).[35] Specifically:

**High-cost cases account for nearly three-fourths of Medicaid spending in the community.** Seventy-two percent of Medicaid spending was attributable to only 10 percent of Medicaid beneficiaries in the community. Medicaid spending is more concentrated among its most expensive beneficiaries than is Medicare or employer-sponsored health insurance spending. Medicaid spending on these individuals during 2002 equaled or exceeded $7,770. These high-cost beneficiaries are more likely than other Medicaid beneficiaries to be women, poor, non-Hispanic white and rural residents. Nearly one in three of the top 10 percent of high-cost Medicaid beneficiaries is also eligible for Medicare as well (i.e., dual eligible).

**Most Medicaid spending for high-cost beneficiaries in the community is for hospital care and home health services.** Nearly two-thirds of all the costs paid by Medicaid for high-cost beneficiaries in the community were for hospital care (40 percent) and home health (24 percent). Another 18 percent of spending for this population was on prescription drugs. Over half (56 percent) of high-cost Medicaid beneficiaries were hospitalized in the last year.

**Chronic illnesses are common among high-cost beneficiaries in the community.** A large fraction of high-cost beneficiaries in the community have chronic health problems that require medical management, including heart disease (28 percent), asthma (25 percent) and diabetes (19 percent).

**Medicaid is a major payer for high-cost people in the U.S.** Among all individuals in the community, not just Medicaid beneficiaries, Medicaid pays for about one-fourth (24 percent) of the top 10 percent most costly individuals. To put this in perspective, this is over 30 times more than the number of people served by medical high-risk pools nationwide (181,441).[36] These data understate Medicaid's role in paying for high-cost cases because they exclude nursing home residents and other institutionalized beneficiaries, for whom Medicaid is the dominant payer.

Three policies could improve the quality of care, and possibly reduce the costs, for high-cost cases in Medicaid.

- **Medical management.** One policy option for Medicaid reform is better medical management of high-cost cases. Analysts in Georgia[37] and Washington[38] have recommended that their state Medicaid programs focus case management on high-cost Medicaid beneficiaries or on beneficiaries with conditions that are associated high Medicaid expenses, such as asthma, diabetes, and heart failure. In a letter to state Medicaid directors, CMS has clarified the circumstances under which Federal matching funds are available for disease management.[39] A number of states have

implemented disease management programs that target high-cost Medicaid beneficiaries, such as high-cost individuals with schizophrenia and other mental health conditions.[40] While it seems plausible that medical management of high-cost Medicaid beneficiaries can reduce overall Medicaid expenditures, there is no good evidence at this time on the magnitude of such savings.[41] There is little doubt, however, that medical management is far more likely to improve the quality of care and health outcomes for high-cost Medicaid beneficiaries than raising cost-sharing or reducing benefits.

- **Electronic medical records**: In the Center for American Progress's health plan, we call for greater Federal investment and leadership on implementing an electronic infrastructure in the health system. The use of computerized prescriptions can halve prescribing errors,[42] and computerized records can dramatically lower days spent in intensive care.[43] It can also reduce total health care costs through administrative and clinical efficiencies. Given its concentration of spending among a few, medically complicated individuals, Medicaid could especially benefit from such information technology. Demonstrations of reimbursement and programmatic changes specifically designed to encourage the implementation of such technologies could be financed through Medicaid. To encourage the development of the information technology infrastructure, Medicaid could apply a 90 percent matching rate to such investments which would contribute to the coordination of care for high-cost cases.

- **Improved prevention**. High-cost beneficiaries typically have multiple, chronic conditions, some of which may be prevented. The Center's health plan calls for a national focus on wellness, carving it out of existing programs to centrally finance while encouraging local delivery system innovation. Short of this, states could, through demonstration waivers, develop such community-based prevention models to improve rates of immunization and screening for diseases like diabetes and high-blood pressure, for example. Medicaid might also benefit from aggressive efforts to curb the rise in obesity, which one study suggests accounted for 27 percent of the all U.S. inflation-adjusted, per-capita spending increase between 1987 and 2001.[44] About 4 million children on Medicaid are obese; these children's health could be improved and Medicaid costs reduced by early interventions.[45]

***Costs Driven by Deteriorating U.S. Coverage System***

Lastly, one cost driver in Medicaid that we did not discuss in our recent Medicaid papers, but do so in our overall health plan, is the growing crisis in the U.S. health care system. Since 2000, the number of uninsured rose by 5 million, to 45 million or nearly 16 percent of all Americans.[46] There are more uninsured Americans than the total population of Canada or people living worldwide with AIDS.[47] The lack of coverage exacts a large personal financial toll, running up debt and contributing to personal bankruptcy.[48] And, it results in billions of dollars in uncompensated care costs that get placed on and passed through the health system.[49] Uninsurance is perhaps the most important, but not the only, problem in the system. In 2004, the cost of employer-based health benefits increased at a rate five times higher than that of wages; since 2000, the family share of such coverage

increased by over 60 percent.[50] This not only strains the middle class but affects Medicaid. Since 2000, employers reduced health care coverage by 4.8 million people and Medicaid enrollment increased by 5.8 million.[51] Some of this rise in the uninsured reflects a worsening economy, with higher unemployment and lower income. Indeed, poverty rose for the third straight year in 2003, and median income has failed to rise.[52] It also reflects fewer small firms offering coverage, a decline in dependent coverage in firms, and a rise in the uninsured even among large firms.[53] As such, Medicaid's problems are the "canary in the coalmine" for larger, systemic failures.

We at the Center for American Progress think that the answer is not Medicaid reform but health system reform. We agree with the Institute of Medicine: we should commit to covering all Americans by the year 2010.[54] Fixing only Medicaid will not prevent a further erosion in private coverage, and vice versa: stabilizing private coverage will not be sufficient to meet Medicaid's coverage and financing deficits. And the vexing problem of health costs in the U.S. can only be addressed by looking at the entire system. To this end, our plan calls for expanding coverage to all, improving it for all through better quality and efficiency, and paying for these investments, through a small, dedicated value-added tax. The full plan is described elsewhere;[55] its major coverage components are described below.

- **Simplify and increase Federal support for Medicaid**. Under the proposal, Medicaid would be simplified and strengthened to fulfill its role as a safety net for all low-income people. The plan would extend Medicaid to cover all individuals below a certain income level (e.g., 100 to 150 percent of the poverty level). As such, it would end the complex and state-specific eligibility categories in favor of a simple means test. In doing so, the would increase the share of program costs paid for by the Federal government so that state costs of this Federal-state partnership program would not increase. By financing this expansion through a broad-based tax, it would spread the cost of this expansion across all states, not expecting poor states with large uninsured problems to come up with new financing.

- **Stabilize private group coverage.** The plan would strengthen employer coverage and would supplement it with a pool modeled on the Federal Employees Health Benefit Plan. This new pool would be open to (1) anyone who lacks access to job-based insurance – a problem for about 80 percent of all uninsured people;[56] (2) the 6 percent of non-elderly Americans who purchase coverage in the individual market today;[57] and (3) all employers, irrespective of size. Reinsurance in the pool would be used to prevent unexpectedly high premiums due to enrollment of high-cost individuals. Beyond the pool, the Center's plan would ensure that no individual pays more than a certain percent of their income (e.g., 5 percent of income) on health insurance premiums. This protection, administered as a refundable tax credit, would apply to employer-based health insurance as well. Since employer contributions would continue to be excluded from employees' taxable income, irrespective of where they purchase coverage, employers' voluntary contributions toward the cost of health benefits likely would not change substantially. Taken together, these policies would reinforce and expand private, group insurance.

## Concerns about the Upcoming Debate

As important as it is to engage in a discussion of ideas around Medicaid, it is equally important to recognize the context for the debate. The budgetary and political environment may take good ideas off the table and steer toward others that could weaken rather than strengthen this vital program. Four such concerns are outlined below.

### *Constraints of Budget Resolution*

While this hearing has focused on the rich array of Medicaid reform options, this Congress is focused on deficit reduction. Rather than raising revenue to finance an improved and expanded health system, the resolution calls for reducing revenue and cutting Medicaid. Indeed, it can be argued that the $10 billion, five-year Medicaid cut is not balancing the budget but, instead, partially financing the resolution's $70 billion tax cut which will likely disproportionately benefit the wealthiest Americans.[58] The constraints of the resolution also probably mean that any policies that increase Medicaid spending must be offset through Medicaid cuts. This could force a morally troubling use of "savings" from policies like higher cost sharing for poor children, parents, and persons with disabilities to finance expansions to higher-income populations. As such, the fact that Medicaid reform is being considered in the context of the budget resolution does not just restrict but could distort policy options.

The Governors' proposal, recognizing this context, suggests that some of the likely tax cuts be directed toward health and long-term care insurance, to alleviate the pressure on Medicaid. But, the reverse could happen. The President's tax credit for insurance in the individual market will not be a substitute for many, if not most, Medicaid beneficiaries. The $1,000 for individuals will be insufficient for policies that typically cost much more than that, and individuals with health problems are unlikely to find an affordable policy if they are offered any policy at all.[59] Thus, states will be left with that small set of high-cost cases regardless. Moreover, a number of economists suggest that this specific tax credit could cause a drop in employer coverage and shift toward the individual market and, inadvertently, Medicaid, thus increasing its costs.[60] Lastly, in both the health and long-term care policies, most of the tax subsidies would go to people who already have insurance. In particular, the $25 billion over 10 years spent on the long-term care insurance tax deduction would primarily go to high-income people who would likely never qualify for Medicaid anyway. These precious taxpayer dollars could – and should – be better spent.

### *Policy versus Politics*

As a former budget official, I believe that an efficient Medicaid is a strong Medicaid, and support policies that target and reduce any excess spending. That said, experience suggests that finding such policies and steering them through the political process is easier said than done. Failure to find an acceptable Medicaid offset that is one-fifth the

size of the cuts called for by Congress has blocked the bipartisan Family Opportunity Act for five years.[61] And, while Congress supported a new, controversial commission to find $10 billion in Medicaid cuts, it rejected its existing bipartisan Medicare commission's call for $20 billion-plus in savings from overpayments to managed care plans.[62] Arguably, this reflects the power of politics to shape the options under consideration. These same forces will likely exert themselves against some of the policies to reduce Medicaid costs. Pharmacists oppose the pharmacy reimbursement cuts; AARP oppose tightening asset transfer policies; and surely the drug industry would oppose some of the policies regarding the drug rebate I raised in this testimony. This could lead to few options except for coverage reductions to achieve the $10 billion in savings. Alternatively, it could revive the idea of making difficult spending reductions behind the veil of caps in Federal funding. Two years ago, the President proposed granting the types of flexibility the Governors now request in return for an upper limit on spending for some or all Medicaid services. Such caps could leave states as well as beneficiaries with inadequate assistance and unmet needs.[63]

***Erosion of Access***

Independent of the budget cuts called for by Congress, the Governors propose increasing cost sharing and reducing benefits for people currently eligible for Medicaid. This may produce some budget savings but at a cost – in economic and human terms – that may be too high. Myriad studies have shown that, for people with very limited income, any cost sharing can deter use of care – whether it is necessary or not. If needed care is deferred, it could result in preventable hospitalization that increase the overall costs of the system, through uncompensated care, if not Medicaid costs directly.[64] It also contributes to the challenges that poor people have in escaping poverty. The Institute of Medicine documented the productivity loss due to lack of coverage;[65] cost sharing that prevents timely use of care will similarly lock people in the bottom wrung of the economic ladder. It also could exact a human toll: the Congressional Budget Office warned, after reviewing the evidence, that "poorer individuals facing higher copayments displayed worse health on some measures."[66]

The Governors also calls for flexibility to design specific benefits packages for different populations. This policy was not included in the CBO options for deficit reduction, probably because it is hard to design a policy in this regard that saves money. If an individual does not need a service, Medicaid does not pay for it. Those who do need a range of benefits are the 10 percent of beneficiaries who account for nearly three-fourths of Medicaid spending. Cutting benefits for these people is "penny wise but pound foolish," probably resulting in higher hospitalization and nursing home costs. Yet, exempting them means that very little savings will result. Moreover, the idea raises a question about whether variation is always desired; should a child with cystic fibrosis get a different set of services depending on where she lives; what are the different benefit needs of a poor senior in Maine versus Florida?

There is a role for cost sharing and benefit flexibility for certain populations in Medicaid. Low-income workers covered through expansions may be able to afford premiums and

cost sharing. Because it targets only children above poverty, such flexibility – within limits – is allowed in SCHIP. However, these expansion groups are very different than those at the core of Medicaid's mission: poor, disabled veterans, seniors who live on extremely limited Social Security benefits, families whose income is less than 60 percent of the poverty threshold, the median upper income level for families in Medicaid today. Some state officials recognize this; the National Academy of State Health Policy working group on Medicaid reform did not recommend reduced coverage for people below poverty.[67] This is because, in truth, there is no such thing as partial access – you have it or you don't, and if Medicaid beneficiaries don't, then the program has failed in its mission.

***Reduced Accountability***

My last concern about the options under consideration is that the legal underpinnings of Medicaid may be weakened. The Governors' proposal calls for automatic and fast-track Section 1115 waiver approval. Such waivers, while intended to test models for improving Medicaid's achievement of its goals, have frequently been used to circumvent key elements of Medicaid law, according to the Government Accountability Office.[68] In 2001, about 20 percent of all Medicaid spending was governed by waiver terms and conditions at the discretion of the Secretary of Health and Human Services – more than the entire budgets of the Departments of Agriculture and Veterans Affairs.[69] Putting 1115 waivers on "autopilot" would weaken the role of Congress as a partner in this important program. Another policy in the Governors' proposal that could have even more far-reaching effects is the proposed limitations on judicial consent decrees and other court orders. This proposal could make it difficult for individuals, providers, and even Federal authorities to seek enforcement of Medicaid law. This would be a dangerous precedent to set for Medicaid, as well as and other state-Federal partnership programs.

In closing, it is appropriate that Congress is examining Medicaid's progress, prospects and problems in 2005, the year of its 40th birthday. Improvements can and should be made in its provision of high-quality, accessible care to all vulnerable people. In terms of its cost drivers, a number of policy options exist to reduce prescription drug spending, address the gaps in the long-term care system, and manage care for high-cost cases. While these policies could help in the short-run, Medicaid's problems are the system's problems, and broader reform is needed. In the meantime, caution must be taken given the context for the discussion – a restrictive budget resolution – and the pressure that may come to take the path of least resistance and reduce coverage – and access – for the lowest income and sickest in our nation.

**Notes**

[1] For a description of the event and access to the reports, see http://www.americanprogress.org/site/apps/nl/content3.asp?c=biJRJ8OVF&b=593305&ct=927753

[2] For a description of the initiative, see http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=477169

[3] Section 1901. *[42 U.S.C. 1396]* "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of

necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

[4] A. Davidoff, A. Yemane and E. Adams, *Health Coverage for Low-Income Adults: Eligibility and Enrollment in State Programs, 2002*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, February 2005; S. Zuckerman et al., "Changes in Medicaid Physician Fees, 1998-2003," *Health Affairs Web Exclusive*, June 23, 2004; D. Grabowski, J.J. Angelelli, and V. Mor, "Medicaid payment and risk-adjusted nursing home quality measures," *Health Affairs* 23(5): 243-52, September 2004.

[5] M. Lillie-Blanton and C. Hoffman, "The Role of Health Insurance Coverage in Reducing Racial Disparities in Health Care," *Health Affairs* 24(2): 398-408, March-April 2005; L. Dubay et al., "Changes in Prenatal Care Timing and Low Birth Weight by Race and Socioeconomic Status: Implications for the Medicaid Expansions for Pregnant Women," *Health Services Research*, June 2001; Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in American*. Washington, D.C.: National Academy of Sciences, June 2003; J. Crowley and R. Elias, *Medicaid's Role for People with Disabilities*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, August 2003.

[6] J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40(4): 323–342, 2003; Policy Brief, *Medicaid: A Lower-Cost Approach to Serving a High-Cost Population*, Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, March 2004.

[7] J. Holahan and A. Ghosh, "Understanding the Recent Growth in Medicaid Spending," *Health Affairs* W5 52-62, January 26, 2005.

[8] See Centers for Medicare and Medicaid Services "Managed Care Trends" http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf; and http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf; administrative costs discussed in Hadley and Holahan, op. cit..

[9] B. Bruen and A.Ghosh, *Medicaid Prescription Drug Spending and Use.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004.

[10] S. Heffler, et al., "U.S. Health Spending Projections for 2004 – 2014*," Health Affairs Web Exclusive*, February 23, 2005.

[11] Dear State Medicaid Director letter dated September 18, 2002 accessed at http://www.cms.hhs.gov/states/letters/smd91802.pdf.; *Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs (9/9/04).*

[12] K.D. Gifford and S. Kramer, *Federal Policy Options to Contain Medicaid Drug Costs*. Washington, D.C.: The Center for American Progress, June 2005.

[13] Department of Health and Human Services, Office of Inspector General, *Variation in State Medicaid Drug Prices,* OEI-05-02-00681, September 2004; see also, testimony presented at hearing on *Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much* before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, December 7, 2004.

[14] Part B drugs include drugs furnished incident to a physician's service, durable medical equipment drugs, and other drugs covered by statute, such as oral immunosuppressive, cancer, and antinausea drugs.

[15] Department of Health and Human Services, Office of Inspector General, 2004, op. cit.

[16] National Governors Association. 2004. EC-3. Medicaid Drug Rebate Program. http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_3716,00.html

[17] J.R. Wilke, "Cases, Fines Sour in Fraud Probes of Drug Pricing," *Wall Street Journal*, A1, June 7, 2005.

[18] U.S. Government Accountability Office, "*Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States,"* February 2005, GAO-05-102.

[19] R. Padrez, J. Blum and D. Mendelson, *Use of Oregon's Evidence-Based Reviews for Medicaid Pharmacy Policies: Experiences in Four States*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2005.

[20] Pub. L. 108-173, for a description, see A. Schneider, *The "Clawback": State Financing of the Medicare Drug Benefit.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004.

[21] CBO Letter dated January 23, 2004 to the Honorable William H. Frist, M.D. accessed at http://www.cbo.gov/showdoc.cfm?index=4986&sequence=0.

[22] G. Anderson et al., "Marketwatch: Doughnut Holes and Price Controls," Health Affairs Web Exclusive, W4-396-404, July 21, 2004.

[23] R. Jensen, *The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2005.
[24] U.S. General Accounting Office, *Medicaid After Welfare Reform.* Washington, D.C.: GAO HEHS-99-163, September 1999.
[25] J. Rovner, "Snag in Mailing of Medicare Drug Notices," *National Public Radio*, June 7, 2005.
[26] V. Smith, K. Gifford, and S. Kramer, *Implications of the Medicare Modernization Act for States: Observations from a Focus Group Discussion with States*. Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2005.
[27] J. Feder, *Long-Term Care and Medicaid: The Critical Role of Public Financing.* Washington, D.C.: The Center for American Progress, June, 2005.
[28] E. O'Brien and R. Elias, *Medicaid and Long-Term Care*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2004.
[29] J. Holahan, "Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?" Chapter 6 in J. Holahan, A. Weil, and J.M. Wiener, *Federalism and Health Policy.* Washington, D.C.: The Urban Institute Press, 2003.
[30] M. Huber and P. Hennessy, OECD, Directorate for Employment, Labour and Social Affairs, "Financing Long-term Care: International Comparisons," presented at Academy Health 2004 Research Meeting, San Diego, CA.
[31] Note: this idea is developed in a draft paper by A. Tumlinson and J. Lambrew, "Linking Medicare and Private Insurance for Long-Term Care," submitted to the Robert Wood Johnson Long-Term Care Financine Project, September 2003; it is not part of Dr. Feder's paper or recommendations.
[32] A. Ahlstrom, E. Clements, A. Tumlinson and J. Lambrew, *The Long-Term Care Partnership Program: Issues and Options.* Washington, D.C.: Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004.
[33] Congressional Budget Office, *High-Cost Medicare Beneficiaries.* Washington, D.C.: CBO, May 2005.
[34] L. Blumberg and J. Holahan, "Government a Reinsurer: Potential Impacts on Public and Private Spending"*, Inquiry*, Summer 2004.
[35] A. Schneider, J. Lambrew and Y. Shenouda, *Medicaid Cost Containment: The Reality of High-Cost Cases*. Washington, D.C.: The Center for American Progress, June 2005.
[36] Council on Affordable Health Insurance. *High Risk Health Insurance Plans: Past, Present and Future*, November 2004.
[37] K. Minyard and K. Gardner*, "…1% of Medicaid Members Generate 23% of Expenditures…" An Argument for Case Management*, Georgia Health Policy Center, October 2003.
[38] S. Lerch and J. Mayfield, *High-Cost Medicaid Clients*. Washington State Institute for Public Policy, December 2000.
[39] Letter from D. Smith, Center for Medicaid and State Operations to State Medicaid Directors, SMDL #04-002, February 25, 2004.
[40] S. Gelber and R.H. Dougherty, *Disease Management for Chronic Behavioral Health and Substance Use Disorders.* Princeton, NJ: Center of Health Care Strategies, Inc., February 2005.
[41] A CBO review of published studies concluded that, with respect to disease management programs for congestive heart failure, coronary artery disease, and diabetes mellitus, "there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health services." Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, October 13, 2004.
[42] D.W. Bates et al., "Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors." *Journal of the American Medical Association* 280(15): 1311-16, 1998.
[43] W.E. Hammond, *Electronic Medical Records: Getting It Right and Going to Scale,* January 2004, www.cmwf.org/publications/publications_show.htm?doc_id=221459 (31 January 2005).
[44] K. Thorpe et al., "Trends: The Impact of Obesity on Rising Medical Spending," *Health Affairs Web Exclusive*, W4-480-86, October 20, 2004.
[45] J. Rosenthal and D. Change, *State Approaches to Childhood Obesity: A Snapshot of Promising Practices and Lessons Learned*. Portland, ME: National Academy for State Health Policy, April 2004.
[46]J. Holahan and A. Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, September 2004..

[47] J. Lambrew, "Uninsured Americans: 45 Million Uninsured Americans." Washington, D.C.: The Center for American Progress, August 26, 2004.
[48] D.U. Himmelstein et al., "Marketwatch: Illness and Injury as Contributors to Bankruptcy," *Health Affairs Web Exclusive*, W5-63-73, February 2, 2005.
[49] J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured , May 10, 2004.
[50] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2004 Annual Survey*. Washington, D.C.: Kaiser Family Foundation, September 2004.
[51] Holahan and Ghosh, 2004, op. cit.
[52] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2003.* Washington, D.C.: U.S. Government Printing Office, 2004.
[53] Kaiser HRET, 2004, op. cit.; S. Glied, J.M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms.* New York: The Commonwealth Fund, October 2003.
[54] Institute of Medicine, *Insuring America's Health: Principles and Recommendations*. Washington, D.C.: National Academy of Sciences, January 2004.
[55] J.M. Lambrew, J. Podesta , and T. Shaw, "Forging Change in Challenging Times: A Plan for Extending and Improving Health Care," *Health Affairs* W5-119-132, March 23, 2005.
[56] B. Garrett, *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility and Participation Patterns in 2001*, Washington, D.C.: The Urban Institute, July 2004.
[57] Holahan and Ghosh, 2004, op. cit.
[58] J. Horney, *Assessing the Conference Agreement on the Budget Resolution*. Washington, D.C.: Center on Budget and Policy Priorities, May 6, 2005..
[59] J. Gabel et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*. New York: The Commonwealth Fund, May 2002; J.D. Reschovsky and J. Hoadley, "The Effect of Tax Credits for Nongroup Insurance on Health Spending by the Uninsured," *Health Affairs Web Exclusive*, February 25, 2004.
[60] J. Gruber, *Cost and Coverage Implications of the President's Health Insurance Tax Credit and Tax Deduction Proposals.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, March 2004; J. Sheils, *Bush and Kerry Heath Care Proposals: Cost and Coverage Compared.* Washington, D.C.: The Lewin Group, September 21, 2004.
[61] S. 622, the Family Opportunity Act, as scored by the Congressional Budget Office on September 10, 2003.
[62] Daily Health Policy Report, "MedPAC Agrees To Draft Recommendations, Including Elimination of $10B Fund for Medicare PPOs," Kaisernetwork.org, April 22, 2005.
[63] J. Holahan and A. Weil, *Block Grants Are the Wrong Prescription for Medicaid*. Washington, D.C.: The Urban Institute Health Policy Online, 2003; C. Mann, M. Nathanson and E. Park, *Administration's Medicaid Proposal Would Shift Fiscal Risk to States.* Washington, D.C.: Georgetown University Institute for Health Policy Research and Center for Budget and Policy Priorities, 2003; J.M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals" *Milbank Quarterly* 83(1): 41-63, March 2005.
[64] Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996. See also S. Artiga and M. O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2005 and Ku, *The Effects of Increasing Cost-Sharing in Medicaid: A Summary of Research Findings*. Washington, D.C.: Center on Budget and Policy Priorities, May 31, 2005.
[65] Institute of Medicine, 2003, op. cit.
[66] Congressional Budget Office, *Budget Options*, Washington, DC: CBO, February 2005.
[67] National Academy for State Health Policy, *Making Medicaid Work for the 21st Century*, January 2005.
[68] U.S. General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*. Washington, D.C.: GAO-02-817, June 2002.
[69] Kaiser Commission on Medicaid and the Uninsured, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview.* Washington, D.C., July 20, 2001.