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# What are States Doing to Control Medicaid Costs and Why is it so Hard?

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**W**isconsin Medicaid officials indicated that the primary factor behind growth in Medicaid expenditures in 2004 and 2005 was an increased case load. Other important factors were the rising costs of pharmacy/prescription drugs and cost-based providers such as long-term care institutions and federally qualified health centers. In 2004, Wisconsin reported plans to control costs by reducing or freezing provider payments, controlling prescription drug costs, increasing copayments, targeting fraud and abuse, and implementing long-term care initiatives. The Wisconsin Department of Health and Family Services estimates that its cost-containment initiatives saved \$460 million between 2003 and 2005.

**In 2004, Medicaid spending across the U.S. grew faster than all other state programs.**

Every state is grappling with the same problem: how to maintain Medicaid benefits to as many people as possible when enrollments and medical costs are increasing but revenues are not. In 2004, for example, Medicaid spending across the U.S. grew faster than all other state programs. It is no surprise that every state has adopted at least one Medicaid cost-containment measure. In Wisconsin, cost-saving measures have included freezing or cutting provider payments, negotiating lower prescription drug prices, adopting a preferred drug list, and increasing premiums for BadgerCare.

After three years of intense fiscal stress, the revenue picture looked better for FY 2005 and enrollments were growing at a slower pace. Despite this improved prognosis, several factors continue to place pressure on states to contain Medicaid costs. The cost-containment strategies states have adopted include reducing provider payments, reducing prescription drug costs and targeting fraud and abuse. The nine most common strategies, which are presented in this chapter, are based on a 50-state survey of Medicaid administrators conducted in the summer of 2004.

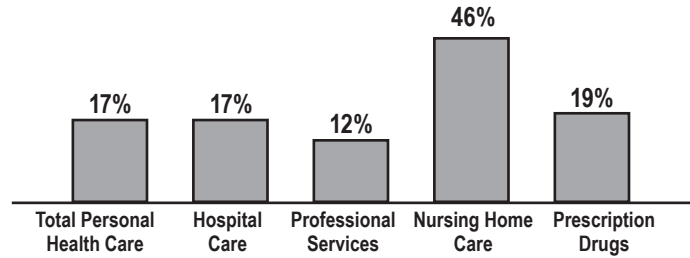
## What Is Medicaid and What Role Does It Play in Our Health Care System?

Medicaid is a publicly funded health insurance program that provides coverage to low-income children, families, seniors, and people with disabilities. Medicaid also fills gaps in Medicare coverage for many low-income seniors, particularly for prescription drugs and long-term care. It is the largest publicly funded health insurance program; it provided health and long-term care coverage to 52 million low-income children and adults in FY 2004, compared to 42 million covered by Medicare. Medicaid also supplements Medicare coverage for 7 million low-income seniors and people with disabilities enrolled in both programs.

Medicaid covered 807,000 Wisconsin residents sometime during FY 2004.<sup>1</sup> This is equivalent to 15% of the state's population. Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care and 19% of prescription drugs (see Figure 1).

Figure 1. Medicaid as a Share of National Health Care Spending, 2003

**Medicaid pays for nearly half of nursing home care.**



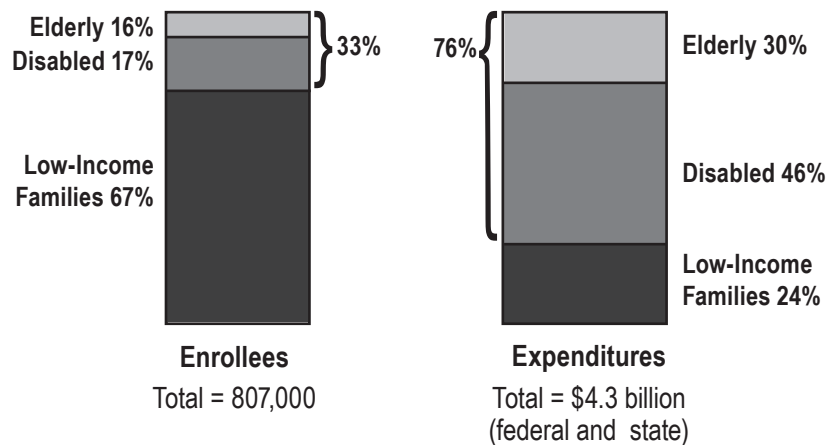
Source: Smith, C. et al. (2003, January/February). *Health Spending Growth Slows in 2003. Health Affairs, 24(1), 185-196*

### Where Does Most Medicaid Spending Go?

Although low-income children and families represent about 75% of Medicaid beneficiaries nationally, they account for only one-third of the expenditures. On the other hand, elderly and disabled individuals represent just one-quarter of the beneficiaries, but account for 70% of the expenditures, reflecting their intensive use of acute and long-term care services.

**Spending in Wisconsin.** This pattern holds true in Wisconsin. In FY 2004, children and families represented 67% of the Medicaid recipients while accounting for only 24% of the expenditures (see Figure 2). Elderly and disabled recipients combined accounted for 33% of the recipients and 76% of Medicaid expenditures.<sup>2</sup>

Figure 2. Majority of Wisconsin's Medicaid Expenditures on Elderly and Disabled, FY 2004



Source: Wisconsin Department of Health and Family Services. (2005, May). *Wisconsin Medicaid Program*.

## Are Medicaid Expenditures Increasing or Decreasing?

In FY 2004, average state Medicaid spending increased 9.5% from the year before. This increase was slightly higher than the 9.4% growth rate in FY 2003, but lower than the average growth rate of 11.9% that occurred over the 2000-2002 period. These overall increases reflect the effects of both increasing caseloads and increasing per capita costs. As a comparison, private insurance premiums (which are a measure of per capita costs) increased 11.2% in FY 2004. State administrators cited several key factors as top drivers of Medicaid spending growth in FY 2004. The most frequently mentioned factors included:

- ◆ Medicaid enrollment growth
- ◆ Increasing costs of prescription drugs
- ◆ Rising costs of medical care
- ◆ Rising costs of long-term care

**Expenditures in Wisconsin.** Wisconsin Medicaid officials indicated that the primary factor behind growth in Medicaid expenditures in both 2004 and 2005 was an increase in the caseload. The secondary factor was rising costs of pharmacy/prescription drugs. Another important factor was increased costs for services of cost-based providers (such as long-term care institutions and federally qualified health centers).

*The primary factor behind recent growth in Wisconsin Medicaid expenditures was an increased caseload.*

## Is Medicaid Enrollment Increasing or Decreasing?

The average state's Medicaid enrollment has increased each year since 1999, with a peak increase of 9.9% in FY 2002. This enrollment growth trend holds true across almost every state – for example, only three states reported enrollment decreases in FY 2004 (Massachusetts, Oregon, and South Carolina). At the beginning of this fiscal year, Medicaid officials projected an average enrollment growth of 4.7% for FY 2005. Although the pace of enrollment growth has slowed, the growth is still substantial and a significant contributor to the increase in Medicaid spending. State Medicaid officials attributed continued enrollment growth to several factors:

- ◆ The economic downturn, resulting in increasing numbers of low-income uninsured people – particularly children and families (“most significant” factor for 23 states).
- ◆ The effect of eligibility expansions or restorations (10 states).
- ◆ Increased numbers of eligible elderly and disabled because of demographic changes (3 states).
- ◆ Outreach for programs such as the State Children's Health Insurance Program (SCHIP) or food stamps, which identify additional persons eligible for Medicaid (3 states).

**Enrollment in Wisconsin.** Recent growth in Wisconsin's Medicaid enrollments are due to the increases in BadgerCare enrollment for low-income families and SeniorCare prescription drug coverage for low-income seniors.<sup>3</sup>

## Do States Have Sufficient Revenues for Medicaid?

Since 2001, as the national economy worsened and state revenues slowed, states have been forced to cut back on various state programs. They have had to make difficult choices affecting health coverage for millions of low-income people across the country.

In FY 2005, revenues are growing and this trend is expected to continue. However, many individual states are still experiencing large budget shortfalls at the same time their Medicaid costs continue to increase. Additionally, the temporary fiscal relief to states provided by the federal government through the Jobs and Growth Tax Reconciliation Act of 2003 has ended, significantly increasing the state share of Medicaid expenses. Anticipated gaps between revenue and expenditure growth will exert enormous pressures on states to reduce or control costs.

## What Strategies Are States Using to Contain Costs?

Every state implemented at least one cost-containment strategy in FY 2004 and every state reported plans for additional cost saving measures for FY 2005. This will be the fourth consecutive year that states have implemented significant cost-containment initiatives, although a few states planned to adopt modest benefit or eligibility expansions. Most states are implementing a comprehensive set of strategies, rather than a single cost-containment measure, including:

***In 2004, every state implemented at least one cost-containment strategy.***

- ✓ Reducing or freezing provider payments
- ✓ Controlling prescription drug costs
- ✓ Reducing benefits
- ✓ Reducing or restricting eligibility
- ✓ Increasing copayments
- ✓ Expanding managed care
- ✓ Implementing disease management programs
- ✓ Long-term care initiatives
- ✓ Targeting fraud and abuse

**Strategies used in Wisconsin.** Wisconsin used a variety of strategies, as reported on the 50-state survey or in the Wisconsin Department of Health and Family Services' May 2005 publication entitled *Wisconsin Medicaid Program*.<sup>4</sup> In 2004, Wisconsin reported plans to use six of the above nine strategies (provider payments, prescription drugs, eligibility, copays, fraud and abuse, and long-term care). In 2005, the state reported plans to use some of the same strategies as 2004 (provider payments, prescription drugs, managed care expansions, disease management, and long-term care). The Wisconsin Department of Health and Family Services estimates its cost-containment initiatives saved \$460 million in 2003-2005. (See the chapter written by the Legislative Fiscal Bureau for more detailed information about Wisconsin's cost-containment initiatives.)

The following sections discuss the nine cost-containment strategies states are using. (Note: A state may not have reported using a strategy for a particular year, but that does not mean the strategy is not in current use in that state. It may mean the state has not implemented a *new* component of that strategy in either 2004 or 2005.)

## Strategy 1: Reduce or Freeze Provider Payments

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care. Payment reductions or freezes (which actually amount to reductions because of cost inflation) can have an impact on the availability of providers who will accept Medicaid and may reduce access to care. Some, but not all, patients could identify alternative sources of care such as community-based care. Still, when faced with increasing fiscal pressures, many states used this strategy.

- ◆ In FY 2004, all 50 states and the District of Columbia cut or froze payment rates to at least one provider group; 47 states said they would do so in FY 2005.
- ◆ States were most likely to cut or freeze reimbursement rates for physicians (42 states in 2004 and 33 in 2005).
- ◆ Despite payment reductions or freezes to at least one provider group, 46 states increased rates for at least one provider group in 2004 and 43 states planned to do so in 2005. These increases were likely due to increased pressure from providers for catch-up rate increases after several years of cuts or freezes.

**Strategy used in Wisconsin.** Wisconsin froze almost all provider reimbursement rates.

## Strategy 2: Control Prescription Drug Costs

States continued to focus significant attention on controlling the cost of prescription drugs, which have been growing at double-digit rates for several years. Drug cost-containment strategies were implemented by 47 states in FY 2004 and by 43 states in FY 2005.

For 2005, the most frequently used strategies included:

- ◆ Implementing preferred drug lists (29 states)
- ◆ Seeking supplemental rebates (26 states)
- ◆ Placing more drugs under prior authorization (21 states)
- ◆ Greater discounts in what states pay pharmacists for prescription drugs (8 states)

In FY 2005, only 3 states adopted new or higher patient copayments; in FY 2004 15 states had done so. Given that Medicaid rules limit patient copayments to a nominal amount (generally \$3 per service), this drop reflects the possibility that many states had already reached the upper limit of pharmacy copayments and, therefore, could not increase them any more.

**Strategies used in Wisconsin.** In FY 2004 and 2005, Wisconsin implemented several prescription drug cost-control measures: obtaining greater discounts on what Medicaid pays for brand name drugs, increasing the number of drugs subject to prior authorization, adopting a preferred drug list and securing additional (“supplemental”) rebates from drug manufacturers.

***Medicaid provider reimbursement rates are sometimes below the cost of delivering care.***

***In FY 2005, fewer states cut benefits and more restored benefit cuts made in previous years.***

### **Strategy 3: Cut Benefits or Restore Benefits Previously Cut**

In FY 2005, fewer states are cutting benefits and more are restoring benefit cuts made in previous years:

- ◆ Only 9 states cut benefits in 2005, compared to 19 in 2004.
- ◆ 14 states intended to restore previous cuts or expand benefits in 2005, compared to 12 states in 2004.

In general, benefit cuts or restrictions involved optional services, particularly those extended to adults, including elderly and disabled persons. Services that were cut or restricted included:

- ◆ Dental, vision and hearing services for adults
- ◆ Chiropractic and podiatry services
- ◆ Psychological services
- ◆ Physical and occupational therapy
- ◆ Personal care services

**Strategy used in Wisconsin.** In 2004, Wisconsin reported implementing a waiver to add additional coverage for autism services uniquely needed by children with disabilities.

### **Strategy 4: Reduce or Restrict Eligibility**

Reducing eligibility for Medicaid is often difficult for states to do because these reductions affect vulnerable populations who usually have no other access to health insurance. During the recent economic downturn, however, 38 states reduced or restricted Medicaid eligibility over a four-year period (2002-2005). On the other hand, during 2004 and 2005, several states expanded coverage to previously excluded groups, such as the working disabled, people under family planning waivers, or uninsured women with breast or cervical cancers.

Eligibility changes fell into three categories: eligibility rule changes, application and renewal process changes, and premium changes.

***Changes to Eligibility Rules.*** In order to receive the enhanced federal match authorized by the Jobs and Growth Reconciliation Act of 2003, states were required to maintain eligibility through June 2004 at the levels in effect on September 2, 2003. All states maintained their eligibility rules and received the additional funding. Any eligibility restrictions in FY 2004 had to occur before September 2, 2003, but some states did restrict eligibility in various ways. Fewer states are implementing reductions in 2005 compared to 2004, but the changes will affect a larger number of people. The variety of eligibility restrictions in 2004 and 2004 included eliminating continuous eligibility, freezing or reducing income levels for eligibility, or eliminating coverage for people who are more appropriately served in another program.

Ten states expanded coverage in FY 2004 and 15 states did so in 2005. Some states expanded eligibility to previously uncovered groups by increasing the income eligibility level for aged and disabled individuals, eliminating TANF (Temporary Assistance to Needy Families) work requirements in determining eligibility for Medicaid, or enabling disabled workers to buy in to Medicaid coverage.

**Changes to Application and Renewal Processes.** Through the late 1990s and into 2001, states had adopted measures designed to simplify and streamline Medicaid application and re-determination procedures. In the face of budget difficulties, some states have reversed this trend (10 states in 2004 and 4 in 2005). Major changes included:

- ◆ Requiring the enrollee to re-verify eligibility more frequently
- ◆ Eliminating continuous eligibility for certain groups (i.e., requiring periodic reverification of eligibility)
- ◆ Eliminating policies that allow for self-declaration of income; in effect, increasing the amount of required documentation.

**Strategy used in Wisconsin.** Wisconsin implemented measures requiring the verification of income and insurance for BadgerCare.

**Premium Changes.** In a limited number of situations, states can require premiums as a condition of coverage. In 2004 and 2005, a few states implemented premium changes, including:

- ◆ Increased premiums for parents and children covered under expansion waivers (Massachusetts and Vermont)
- ◆ New or higher premiums for disabled workers (Iowa, Louisiana, Minnesota, and Nevada)
- ◆ New premiums on certain disabled children covered under the Katie Beckett rules (Maine)

**Strategy used in Wisconsin.** Wisconsin increased premiums for BadgerCare.

### **Strategy 5: Increase or Implement Copayments**

When imposing patient copayments, states must comply with the federal Medicaid law. It specifies that payments must be nominal – generally defined as \$3 or less per service – and cannot apply to certain services, or certain eligibility groups, such as children or pregnant women. Over the past several years, states have relied more on copayments as part of their cost-containment strategies. A substantial body of research indicates that even nominal copayments can deter low-income individuals from receiving needed care.<sup>5</sup>

In FY 2004, 20 states imposed new or higher copayments; 9 states did so in FY 2005. The most frequent copayment imposed was for prescription drugs (discussed under Strategy 2 – controlling prescription drug costs). A few states increased copayments for:

- ◆ Hospital inpatient and outpatient visits
- ◆ Nonemergency use of emergency rooms
- ◆ Hearing, vision, dental, and therapy services
- ◆ Physician office visits
- ◆ Ambulatory services
- ◆ Home health

***Even small copayments can deter low-income individuals from receiving needed care.***

**Of employers,  
15% responded  
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### **Strategy 6: Implement Managed Care Initiatives**

As in the 1990s, states are turning to managed care to control Medicaid costs. States continue to regard managed care as an important component to improving access and quality of care, but the costs of managed care have grown in many states, making it a less attractive option. In 2004, 15 states made at least one change to their managed care program. Nine states expanded their service areas, 4 states increased enrollment in managed care programs by making it mandatory for some individuals or in some counties, and 3 states expanded or restored coverage for some beneficiaries.

In 2005, 14 states expanded their managed care programs. Nine states expanded service areas, 6 states increased the level of mandatory enrollment, 4 states expanded risk-based managed care throughout the state, and 4 states incorporated dual eligibles and the SSI population into managed care.

**Strategy used in Wisconsin.** Wisconsin is currently expanding managed care to people with disabilities in Milwaukee and Dane Counties.<sup>6</sup>

### **Strategy 7: Implement Disease and Case Management Programs**

An increasing number of states are turning to disease and case management initiatives to help contain costs for diseases such as asthma, diabetes, depression, and chronic heart failure. Between 2002 and 2004, 42 states began such programs. These initiatives are seen as a relatively low cost way to improve health care for people with chronic and disabling conditions, including many adult Medicaid beneficiaries. Cost savings and quality outcomes from these programs look likely but this is not yet conclusive because there are several challenges: 1) participation is voluntary, 2) turnover is high among enrollees, and 3) payment rates to providers are low.<sup>7</sup> However, in a recent health benefits survey of employers, 15% of firms responded that disease management strategies were very effective in containing costs.<sup>8</sup>

The trend among states is toward more comprehensive care management programs, rather than having a specific disease focus. In the future, states may have a more difficult time implementing care management programs because persons eligible for both Medicaid and Medicare will receive their drug coverage from Medicare.

**Strategy used in Wisconsin.** In 2005, Wisconsin reported developing and implementing a program designed to ensure that persons needing mental health prescription drugs receive exactly the medications they need. The program was designed to improve quality of care and also to avoid the possibility of abuse.

### **Strategy 8: Implement Cost Controls on Long-term Care and Home and Community-based Services**

Although long-term care represents over one-third of Medicaid spending, states did not initially adopt cost-containment strategies in this area. However, as other methods of controlling costs have been exhausted, states are beginning to focus on long-term care. Ten states in FY 2004 and 17 states in FY 2005 implemented cost-containment strategies for *long-term care* including:



- ◆ Reducing the number of nursing home beds
- ◆ Reducing the number of days for which Medicaid will pay a nursing home when the resident is in the hospital
- ◆ Reducing payments to nursing homes when a bed is held for a resident who is temporarily away from the facility for a number of days, e.g., during holidays
- ◆ Tightening eligibility criteria
- ◆ Downsizing the capacity of intermediate care facilities for the mentally retarded
- ◆ Changing formulas for nursing home reimbursement

In the past two years, 8 states in FY 2004 and 11 states in FY 2005 implemented cost controls on home- and community-based services (HCBS). HCBS services are provided to frail elderly and disabled persons in their own homes to prevent or delay their need for institutional care. Some states have limited the number of available Medicaid waiver slots for HCBS, which reverses the trend of the past five years when states expanded access to community-based support services as a response to the U.S. Supreme Court decision in *Olmstead vs. L.C.* (June 1999). This decision found that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.

Other cost cutting measures in *home- and community-based services* included:

- ◆ Limiting hours authorized for specific instrumental activities of daily living
- ◆ Restricting private duty nursing hours
- ◆ Reducing the allowable budget for high-cost cases
- ◆ Implementing utilization review procedures

### **Strategy 9: Target Fraud and Abuse**

Many states enhanced ongoing activities or started new activities designed to control fraud and abuse. In some cases, these actions were tied to new management information systems, additional staff, or an increased number of provider audits. Activities included restricting high-use recipients to a single doctor, establishing a new fraud unit, and focusing more efforts on third party liability recoveries. Between 2002 and 2005, 32 states put in place new fraud and abuse mechanisms.

## **What are the New Challenges to Containing Costs?**

As states moved into FY 2005 with a somewhat improved economic picture, several factors presented new challenges. Following are three of the factors for 2005 and 2006 that will impact states' ability to further contain Medicaid spending growth.

### **Federal Fiscal Relief has Ended**

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, greatly increasing the state burden for Medicaid costs. The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided states with an enhanced federal

***Temporary federal relief has come to an end, greatly increasing the state burden for Medicaid costs.***

match rate (FMAP) for Medicaid expenditures. The enhanced FMAP enabled 36 states to resolve Medicaid shortfalls and helped 31 states avoid, minimize, or postpone Medicaid cuts or freezes. With the expiration of the enhanced FMAP, state spending on Medicaid has grown enormously in FY 2005. However, officials in 20 states indicated that the expiration of the enhanced FMAP had been anticipated and the impact minimized.

### **Increased Scrutiny of Special Financing Arrangements**

As states have struggled in recent years to deal with Medicaid shortfalls without undermining essential services to vulnerable populations, some have turned to special financing arrangements to maximize the amount of federal money flowing to states. These arrangements include the use of funds from other governmental units (Intergovernmental Transfers, or IGTs) and/or provider taxes to make up the nonfederal share of Disproportionate Share Hospital payments or Upper Payment Limit reimbursements. At the same time, the federal Centers for Medicare and Medicaid Services (CMS) has increased its scrutiny of these arrangements, often through the Medicaid State Plan amendment approval process. States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

### **Implementation of the Medicare Prescription Drug Benefit**

Implementation of the new Medicare Part D drug benefit that is scheduled to take effect January 1, 2006 has provoked some concern among states regarding people who are eligible for both Medicare and Medicaid (dual eligibles). States reported four common concerns:

- ◆ The greatest concern was about the “clawback” provision of the Medicare law that will require states to make payments to the federal government to help finance the drug benefit for those with dual eligibility (39 states).
- ◆ 16 states were concerned about the requirement for states to perform low-income subsidy determinations.
- ◆ 15 states were concerned that they would actually end up spending more for drug coverage for dual eligibles (through the clawback) than they would have in the absence of Part D.
- ◆ 12 states were concerned about the adequacy of Part D plan formularies.

### **What Is the Outlook for 2005 and Beyond?**

Medicaid played a critical safety net role for many vulnerable individuals during the recent economic downturn. The current financing structure of the program, with federal matching dollars and guaranteed eligibility for those who qualify, allowed Medicaid to meet this need. The challenges discussed above, however, combined with trends of increasing poverty and eroding private insurance will continue to put pressure on Medicaid enrollment and spending growth. States are responding in different ways to these trends:

- ◆ Some states are seeking to control costs through Section 1115 waivers, which give them the flexibility to implement enrollment caps and benefit reductions.

***Increasing poverty and eroding private insurance will continue to put pressure on Medicaid enrollment and spending.***

- ◆ Other states have begun to view Medicaid as an effective means to address the issue of the uninsured and to expand coverage.

The recent period of fiscal stress has regenerated interest at the state and federal levels in restructuring federal Medicaid law. A major issue is the way the program is financed and the roles of the states and the federal government. The direction this discussion takes will have significant implications for state budgets, program beneficiaries, and the ability of the program to serve as part of the safety net for vulnerable populations.

## How Might Cost Containment Strategies Affect Families?

Changes to Medicaid naturally affect not only individual recipients, but also the families in which they live. Family members experience the effects of changes whether related to eligibility expansion or reduction, the requirement of prior authorization for prescription drugs, allowable costs for nursing home care, and many other aspects of Medicaid law and policy. As policymakers continue to grapple with containing Medicaid costs, it is important to consider the many ways in which potential and existing cost-containment measures impact families in intended and unintended ways.

***It is important to consider ways that Medicaid reform may impact families in intended and unintended ways.***

*This chapter is based on the following paper. Complimentary copies of the paper can be downloaded from the Kaiser Family Foundation Web site at [www.kff.org/medicaid/7190.cfm](http://www.kff.org/medicaid/7190.cfm).*

Smith, V., Ramesh, R., Gifford, K., Ellis E., Rudowitz, R., & O'Malley, M. (2004, October). *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

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