Executive Summary

Every state is grappling with the same problem—how to provide Medicaid benefits for vulnerable populations when costs are increasing faster than state revenues. According to the Urban Institute, Medicaid costs in Wisconsin grew an average of 13% annually between 2000 and 2003. The Medicaid program benefitted 807,000 Wisconsin residents or 15% of the population sometime in Fiscal Year (FY) 2004. Medicaid has proven to be a thorny issue for policymakers because it places demands on the state budget, while bringing benefits to the state's low-income individuals and families.

The first chapter by **Martha King**, a 20-year veteran of the National Conference of State Legislatures, describes the Medicaid program, why the program costs so much, who it serves, and how some states have controlled Medicaid costs. Medicaid is an optional program, but all states choose to participate because of the large share of costs underwritten by the federal government—about 58% of Medicaid costs in Wisconsin.

From FY 2002 to 2003, Wisconsin's Medicaid expenditures increased more than $438 million or 12.6%. King discusses several reasons why Medicaid costs have been difficult to rein in. Because Medicaid is an entitlement program, states cannot exclude anyone who qualifies for coverage. This makes budgeting difficult because the number of eligible people can fluctuate with factors such as the economy and eroding private insurance. Medicaid costs are also high because certain beneficiaries such as the low-income elderly and disabled have high medical and long-term care needs. In fact, in Wisconsin, these two groups make up only about 33% of Medicaid beneficiaries, but account for about 76% of program costs. In contrast, children and adults (mostly poor parents and pregnant women) account for about 67% of participants, but only 24% of costs.

John Holahan of the Urban Institute discusses why it has been difficult for states to cut Medicaid benefits, who is covered by Medicaid, how cost effective Medicaid is, and what questions policymakers can ask to guide difficult Medicaid budget decisions. Policymakers have been reluctant to cut Medicaid benefits for several reasons. Some benefits are popular with citizens because they strengthen families and improve human capital. Making cuts in provider payments is hampered by the political power of these groups. Given Wisconsin's federal matching rate of 58%, cutting a dollar in expenditures only saves 42 cents, and cutting optional acute care benefits saves little or no money.

Holahan examines who Medicaid serves and compares low-income people covered by Medicaid to their counterparts who are privately insured. The Medicaid population is much poorer, has less education, and is less likely to be married. Medicaid enrollees are also more apt to be sick or in poor health and have more cognitive and physical limitations than the privately insured poor. When per person costs are compared directly, the costs for Medicaid adults are higher than for the privately insured poor ($4,877 compared to $2,843). However, when adults with fair or poor mental health or any physical limitations are excluded, the spending for non-disabled Medicaid adults ($1,752) is significantly lower than for non-disabled adults who are privately insured ($2,253).

Holahan also examined the services provided by the Medicaid benefit package that are often considered too generous—dental and other optional services. These so-called Cadillac benefits add about 12% to total costs.

Vernon Smith of Health Management Associates discusses what states are doing to control Medicaid costs based on his 2004 50-state survey of state Medicaid administrators. The top drivers of the growth in spending, according to state Medicaid administrators, are Medicaid enrollment growth and the rising costs of prescription drugs, medical care, and long term care. Wisconsin Medicaid officials indicated that the primary driver behind growth in Medicaid expenditures in 2004 and 2005 was an increased caseload. Other important factors were rising costs of prescription drugs and cost-based providers such as long-term care institutions and federally qualified health centers.

Because Medicaid spending in the U.S. in 2004 grew faster than all other state programs, every state adopted at least one cost-containment measure 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.

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. In 2005, the state reported plans to use some of these same strategies (provider payment reductions, prescription drugs savings, managed care expansions, disease management programs, and 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.

The **Legislative Fiscal Bureau** chapter overviews Wisconsin's Medical Assistance (MA), BadgerCare and SeniorCare programs including eligibility, caseload trends, federally required and optional services, expenditures, and recent cost containment initiatives. Most of the recent growth in caseload trends has been low-income families, whose costs are lower than other beneficiaries. Because of a 2003 waiver, the number of women who participate in MA family planning has also increased, as has the number of individuals who qualify due to disabilities. MA recipients over 65 and the BadgerCare caseload have decreased and the state's SeniorCare program has stabilized.

The **Wisconsin Family Impact Seminars** encourages policymakers to consider how Medicaid reform may impact the well being of Wisconsin families in intended and unintended ways. Three examples are given here. First, policymakers can use data on families enrolled in Medicaid to help guide difficult budget decisions. In Wisconsin, children and adults (mostly poor parents and pregnant women) are the majority (67%) of Medicaid recipients, but account for only a small percent (24%) of costs. Second, recent measures to control Medicaid costs in Wisconsin have implications for families. For example, Wisconsin reduced nursing home expenditures by providing the options that many seniors prefer—home and community-based care. For families enrolled in BadgerCare, recent increases in premiums and new employer health care verification procedures may have reduced access to care.

Finally, the eligibility criteria that state and federal policymakers set can affect family decisions, such as whether or not to marry. For BadgerCare, if a mother and father live with their child, they are eligible for benefits whether or not they are married. If a parent and a partner (not the other parent) live with the child, the partner does not receive coverage unless they marry. However, if they marry, it is possible that the joint income of the couple could disqualify them from BadgerCare by raising the family's income above the cutoff. For the SeniorCare program, eligibility is based on federal poverty guidelines, which are based on family size. For an elderly couple, it would probably be easier to meet the income guidelines if they live together rather than marry.