



Containing State Health Care Spending
While Improving Outcomes

A joint research series from the Washington Roundtable and Washington Research Council

THE THRIVE WASHINGTON PROJECT

The Great Recession dramatically changed fiscal conditions in Washington state, possibly forever. The impact of falling revenues and structural budget deficits has elicited a near universal call for a transformative shift in state government. This research series—developed by the Washington Roundtable and Washington Research Council—will provide actionable state policy recommendations that, if enacted, will preserve essential services, lay a foundation for sustainable economic growth and create an environment in which Washingtonians can thrive.

STATE HEALTHCARE COSTS

Growth in spending on health care since the 1997-99 biennium has eclipsed expenditure increases in other major areas of the Washington state budget, including K-12 education, higher education and transportation. More than one-third of the Near General Fund State (NGFS) operating budget is now dedicated to health-related spending. In the late 1990s, health-related

expenditures accounted for only one-quarter of the budget.

Rapid growth in health care spending is squeezing out funding for other priority services and expanding the state's enduring structural deficit. Washington cannot solve its structural deficit and focus resources on priorities like education that will drive long-term economic growth until it contains health care spending growth—through policy reforms, better health management and healthier outcomes.

Policy changes in three major programs—Medicaid, state employee health benefits and the Basic Health Plan (BHP)—could significantly reduce the long-term cost curve. Medicaid helps to fund a number of state programs, the largest of which is Medical Assistance. Medical Assistance, state employee health benefits and the BHP comprise 48 percent of state health spending. In this Thrive Washington analysis, we examine the factors driving growth in each of these programs and recommend policies that will assist in containing spending growth while improving outcomes.

EVOLVING IMPACTS OF NATIONAL HEALTH CARE POLICY

The new federal health care law, known as the “Patient Protection and Affordable Care Act” (H.R. 3590), comes with mandates that will increase pressure on state budgets. The

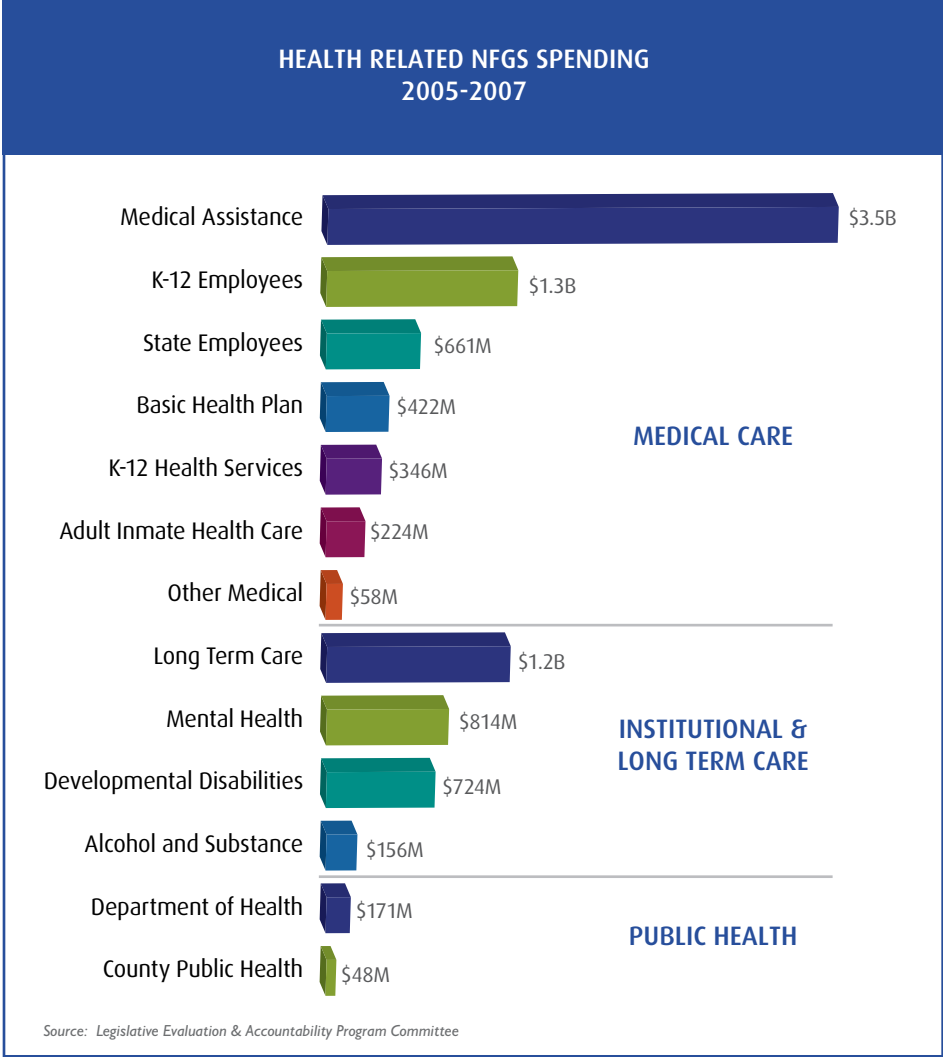
RECOMMENDATIONS

- Obtain Medicaid waivers to gain program flexibility.
- Pursue a health care cost-sharing structure with state employees comparable to that of public and private employees nationwide.
- Follow through on the 2006 legislative mandate requiring all public employees to have the option of a health savings account/high-deductible health plan.
- Bring K-12 employee health coverage under the Public Employees Benefits Board or require school districts to purchase health care as a group.
- Require health assessments and tighten eligibility requirements for the Basic Health Plan, should it be maintained.

1 Containing State Health Care Spending While Improving Outcomes

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Federal health care reform will increase Medicaid spending in Washington by \$8.65 billion from 2014 to 2019.



law requires that most residents have health insurance by January 1, 2014 (this “individual mandate” is being challenged by several states). It also expands Medicaid eligibility and reduces the growth of Medicare payment rates. These provisions, at least initially, will drive up state health care costs.

Health Affairs magazine estimates that total national health spending was \$2.47 trillion in 2009, an increase of 5.8 percent over 2008. Accounting for the anticipated impacts of the new federal legislation, annual national health expenditures are expected to climb 85 percent, reaching \$4.57 trillion by

2019. Correspondingly, health care spending as a share of the economy is projected to rise from 17.3 percent in 2009 to 19.6 percent in 2019. State and local health expenditures (nationally), accounting for the new health care law, are expected to more than double, going from \$285 billion in 2009 to \$610 billion in 2019.

The Kaiser Commission on Medicaid and the Uninsured estimates that the Medicaid expansion provisions of the new federal law will increase spending in Washington state by \$8.65 billion from 2014 to 2019. Over the five-year period, the state’s share will

rise \$380 million, an increase of 1.2 percent over baseline projections. The federal government will fund the additional \$8.27 billion. This is over and above baseline Medicaid spending in Washington of \$63.7 billion from 2014 to 2019, of which the state would pay \$31.8 billion.

THE STATE HEALTH CARE SPENDING CHALLENGE

In 2008, Washington’s Legislative Evaluation and Accountability Program (LEAP) Committee compiled data on state health-related spending per biennium from 1997-99 to 2005-07. This one-time undertaking required access to levels of detail not publicly available; consequently, 2005-07 is the latest available data. That said, the underlying trends have not changed in subsequent years. Further, the infusion of federal stimulus funds makes direct comparisons with past biennia unfeasible.

During the 2005-07 biennium, health-related spending accounted for 33.5 percent of state spending, up from 25.8 percent (1997-99). Additionally, from 1997-99 to 2005-07, each of the three major categories of health-related spending (medical care, institutional and long-term care, and public health) grew more than the major categories of non-health related spending.

Recognizing the unsustainable nature of these trends, the legislature established the Blue Ribbon Commission on Health Care Costs and Access in 2006. As the Blue Ribbon Commission and the Washington Roundtable have recommended, a reduction in costs could be accomplished through better case management, better delivery of health care services, and promotion of value-driven health care.

Washington’s Public Employee Benefits Board (PEBB, the body administering state employee health care benefits) finds that roughly 15 percent of enrollees account for 85 percent of health care costs. Most of the expense is associated with care for chronic

conditions such as heart disease, cancer, stress, depression and obesity. Targeting the high-cost, chronically-ill population with disease management programs is key to controlling costs and improving outcomes.

More effective health care delivery will also reduce costs by minimizing waste and unnecessary care. This can be achieved by using health information technology systems, evidence-based medicine and integrated services. Similarly, improved information systems, public reporting on doctor and hospital performance, and transparent disclosure of the true costs of health care to patients will improve quality and value.

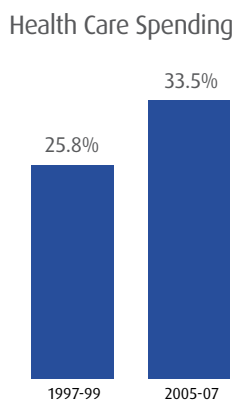
These reforms are discussed in detail in the Washington Roundtable’s 2008 report, “Establishing a High Quality, Value-Driven Health Care System in Washington State,” available at www.waroundtable.com. Over time, they will slow the growth in health care spending and improve outcomes. In the near term, however, the state must take specific steps to address growth in Medicaid, state employee health benefits and the Basic Health Plan.

MEDICAID

The federal-state Medicaid program pays for health and long-term care for low-income individuals and families. The federal government mandates that certain population groups be provided services under Medicaid. Among them: limited income families with children, Supplemental Security Insurance recipients and children under the age of six whose family income is at or below 133 percent of the federal poverty level. Additionally, the federal government requires that eligible groups have access to services (unless the state receives a Section 1115 waiver) such as inpatient and outpatient hospital stays, doctors’ services and x-rays. Beyond that, each state has latitude to set additional Medicaid eligibility and service guidelines.

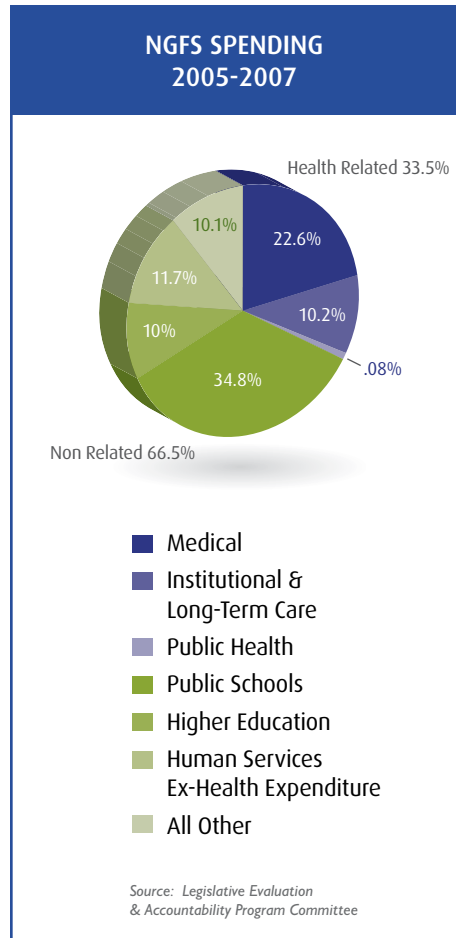
The states are responsible for administering and partially funding Medicaid and they

WASHINGTON STATE BUDGET (Near General Fund State)



3 Containing State Health Care Spending While Improving Outcomes

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By 2011, the number of people served by the state's Medical Assistance program is expected to have increased 61 percent since 1999. This is more than three times state population growth (17 percent) during the same period.

receive non-capped matching funding from the federal government to subsidize the program. Because Medicaid is an entitlement, the federal government must match state spending no matter how high it is. Capped funding would establish a ceiling on the level of federal funds available. The level of matching funding (called the Federal Medicaid Assistance Percentage or FMAP) takes into account average per capita income for each state relative to the national average. As a result, poorer states receive more federal dollars. In no instance can the federal match be less than 50 percent of total costs.

Medical Assistance is the largest of several programs funded by Medicaid. Since

the 1997-99 biennium, Medical Assistance spending in Washington has grown at twice the rate of the NGFS budget. Medical Assistance payments increased from \$1.6 billion during the 1997-99 biennium to \$3.5 billion in 2009-11 (a 113 percent increase). By comparison, total operating budget state expenditures only grew 55 percent and K-12 expenditures grew 52 percent, less than half the rate of Medical Assistance growth.

Growth in Medical Assistance spending would have been even higher, except the federal government paid 13 percent more of the program's costs in 2009-11, reducing state expenditures by \$971 million. Overall, however, spending continued to rise.

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Other programs receiving Medicaid funding include long-term care, mental health and developmental disabilities. According to the state Caseload Forecast Council, long-term care caseloads increased 14 percent from June 2003 to June 2009 and are expected to increase another 17 percent from June 2009 to June 2013. Long-term care costs have risen 51 percent since the 1997-99 biennium, reaching \$1.3 billion in 2009-11. Although state costs for institutional and long-term care decreased in 2009 (due to one-time federal stimulus dollars), overall spending continued to rise.

MANAGING MEDICAID

Unchecked, Medicaid spending will continue to consume a larger and larger share of the state budget, cutting into the funding available for other high priority services, including public schools and higher education.

The lure of federal funding encourages expansion. Conversely, the prospective loss

Since the 1997-99 biennium, Medical Assistance payments in Washington rose from \$1.6 to \$3.5 billion (a 113 percent increase).

of federal aid makes program reduction difficult. States cannot cut their own Medicaid spending without losing the federal match. The American Recovery and Reinvestment Act of 2009—the stimulus—increased the federal match for FY2010 and the first half of FY2011, providing billions in new funding for cash-strapped states. The money came with restrictions, however. States are required to use the increased funding for Medicaid expenditures and to maintain eligibility requirements.

Before stimulus dollars temporarily increased the federal share, Washington's matching percentage was 50.94 in FY2009. Washington's FY2010 FMAP match is 63 percent, which means if Washington wanted to reduce state spending in its program by \$1 it would have to cut overall Medicaid spending by \$2.70.

To stabilize Medicaid costs, Washington should pursue additional federal waivers allowing states more flexibility. Such waivers are used in some form in most states, including Washington.

Washington currently has several Section 1915(c) Home and Community-Based waivers regarding services for the aged, blind and disabled, as well as for individuals with developmental disabilities. Washington has one Section 1915(b) waiver that allows the state to operate a managed care model for mental health services.

Washington does not have any active Section 1115 waivers, which are for research and demonstration projects, but one is under consideration. The 2010 Supplemental Appropriations bill (ESSB 6444) directed the Department of Social and Health Services to seek such a waiver in order to provide federal matching funds for Basic Health Plan and Medical Care Services program enrollees, as a bridge until 2014, when many of those enrollees will be rolled into Medicaid under federal health care reform.

According to the Kaiser Commission on Medicaid and the Uninsured, while many

WHAT IS A MEDICAID WAIVER?

Under the Social Security Act, the Secretary of Health and Human Services may waive certain federal Medicaid requirements in order to give the states more flexibility. These waivers fall into three categories, as described by the Centers for Medicare & Medicaid Services (CMS):

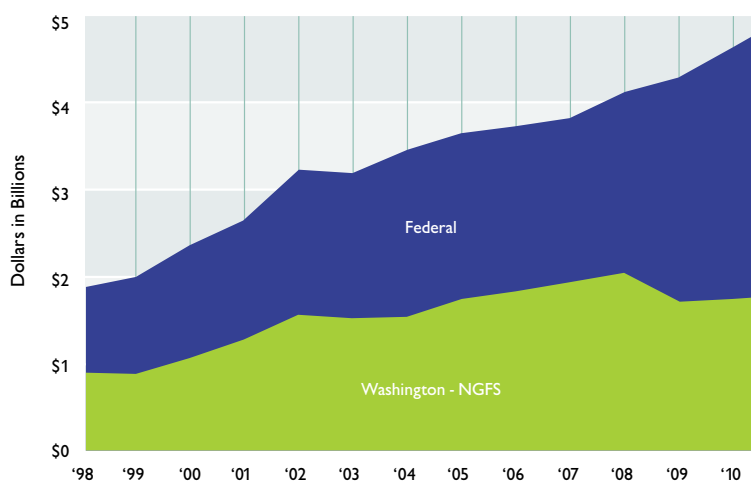
Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915(b) Managed Care/ Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

In order to qualify for a Section 1115 waiver, the proposal must be budget neutral; that is, federal spending cannot rise as a result. A cost-effectiveness test applies to section 1915(b) waivers, and Section 1915(c) waivers must be cost neutral.

RAPID GROWTH IN SPENDING ON MEDICAL ASSISTANCE



Source: Fiscal.wa.gov

Washington should obtain a Section 1115 waiver authorizing capped federal funding to gain control of state Medicaid spending and service delivery.

Section 1115 waivers have historically focused on expanding coverage to more people, however, more recently some states have moved to restructure financing given their interest in “controlling and increasing predictability of program costs as well as ideas about reshaping Medicaid to promote personal responsibility and reflect private market trends.”

Currently, Washington has little control over Medicaid spending. After basic education, Medicaid is the largest protected program in the state budget. Ideally, health care spending would be part of the normal budget process—and the governor and legislature would set priorities and fund them accordingly, free of dedications and mandates. In practice, however, the state budget includes programs and services that policymakers consider off-limits.

A waiver authorizing block grant funding in exchange for more program control would go a long way toward solving this problem. Pure block grant funding is controversial

(there would no longer be a federal coverage guarantee) and has yet to be granted any state. Capped funding is being used instead.

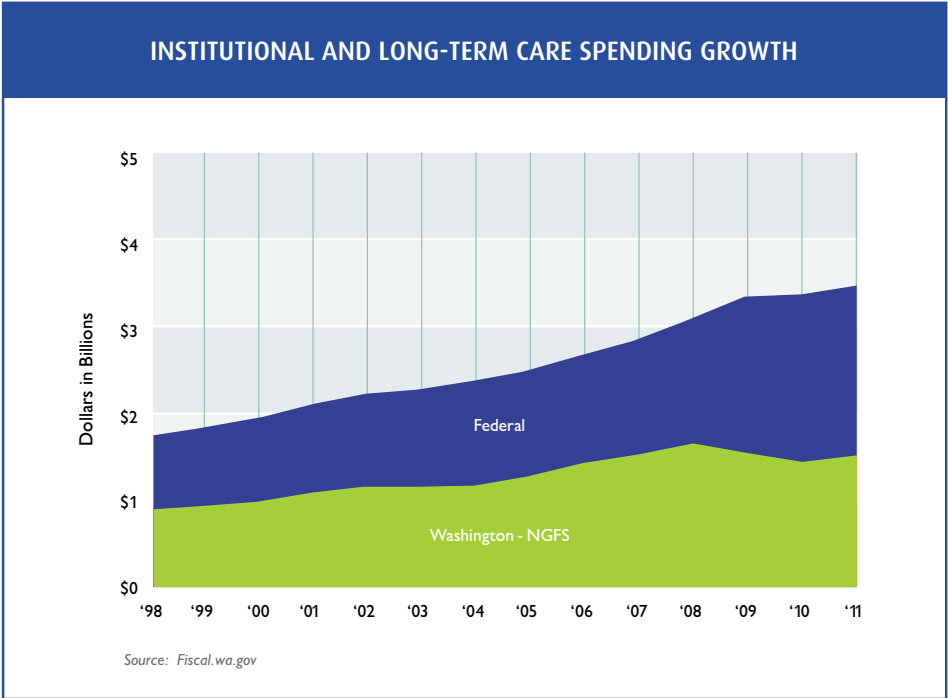
Washington should obtain a Section 1115 waiver authorizing capped federal funding to gain control of state spending and service delivery. The current “open-ended” funding arrangement comes with costly restrictions. If state government had more choices in how it provides Medicaid services, it could realize efficiency gains and cost reductions.

There are successful examples across the country of states using Section 1115 waivers.

- Vermont’s 2005 Global Commitment waiver capped federal funding for acute care in exchange for the ability to use Medicaid funds for other health programs, enable flexibility to reduce benefits, increase cost sharing, and cap enrollment. According to Kaiser, “this waiver established the state as a managed care organization which allows it to pay itself a premium for each

beneficiary it serves. It permits the state to use federal Medicaid funds for state fiscal relief and non-Medicaid health programs. Further, the waiver gave Vermont new flexibility to cut back on coverage.” According to CMS, Vermont estimated in 2009 that the waiver would save the state \$77 million. According to the Kaiser Family Foundation, total Medicaid expenditures in Vermont were \$1 billion in 2008.

- In 2005, Florida received a waiver to pilot a managed care program in the hopes of improving spending predictability. Under the waiver, Medicaid was set up as a defined contribution program. Beneficiaries were given a choice of health plans in pilot program counties. Florida’s request for an extension of the waiver in June 2010 noted that expenditures have been \$4.2 billion less than authorized by the budget neutrality limit. Total Medicaid expenditures in Florida were \$14.9 billion in 2008.
- In 2008, Rhode Island was granted a waiver capping federal funding so the state could expand the availability of alternatives to institutional long-term care, among other things. The state estimated it would save \$358 million over five years. Total Medicaid expenditures in Rhode Island were \$1.8 billion in 2008.
- In 2007, the federal government approved the Healthy Indiana Plan (HIP) as a Medicaid demonstration project. The Kaiser Commission on Medicaid Facts in 2008 described HIP as the first plan providing a “benefit package modeled after a high-deductible plan and health savings account to a low-income population using Medicaid funds.” The plan offers up to \$300,000 annual insurance coverage (\$1 million lifetime) after enrollees meet a \$1,100 deductible. Enrollees pay an income-adjusted monthly premium into a Personal Wellness and Responsibility (POWER) account for medical expenses up to the deductible.



7 Containing State Health Care Spending While Improving Outcomes

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In addition, enrollees are covered for preventative care, independent of the deductible and POWER account.

These demonstrations provide guides to what might be successfully undertaken here. By gaining the flexibility to make choices that will work best for Washingtonians, the state will be better equipped to manage growth in health care spending and improve quality.

STATE EMPLOYEE HEALTH BENEFITS

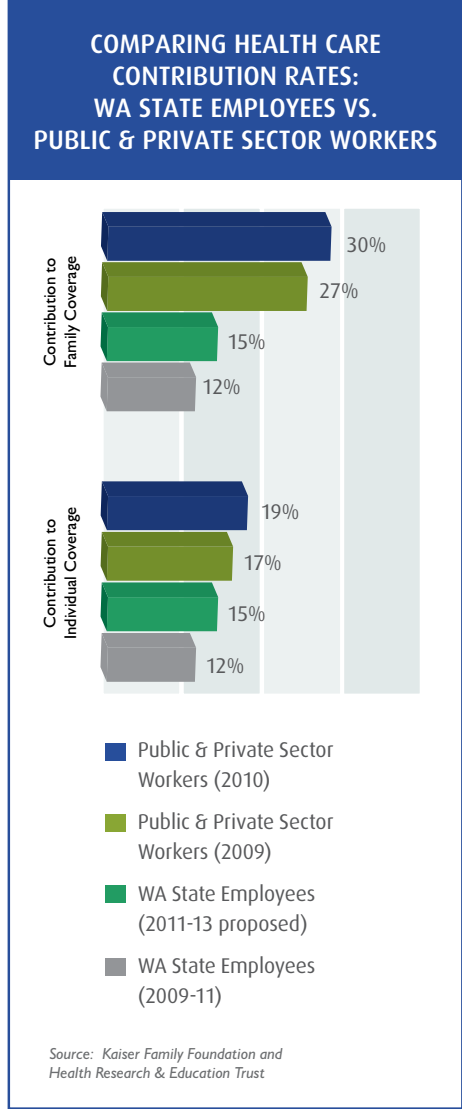
Total NGFS appropriations for Washington state employee and K-12 health care benefits doubled from 1999-01 to 2009-11, from \$1.3 billion to \$2.6 billion. Most of the increase is attributed to higher state contributions per employee and K-12 staff (monthly costs per employee rose from \$436 in FY2001 to \$850 in FY2011).

Currently, Washington pays 88 percent of the premium costs for state employees for individual or family coverage. In 2003-05, state employees paid, on average, 16.3 percent of the cost of their coverage (up from 6 percent in FY2001). In 2005, the first budget enacted after public employees were allowed to bargain collectively, the state employee share of premium costs was reduced to the current 12 percent.

By comparison, the 2010 survey of employer health benefits conducted by the Kaiser Family Foundation and Health Research and Education Trust found that “on average (covered workers) contribute 19 percent of the total premium for single coverage (up from 17 percent in 2009) and 30 percent for family coverage (up from 27 percent in 2009).”

The cost differential between what Washington state employees and their counterparts in the private and public sectors pay is substantial. For all plans (public and private), Kaiser reports the average employee pays \$3,997 for family coverage nationwide. By contrast, Washington state workers enrolled in the Uniform Medical Plan (the most popular of the state plans)

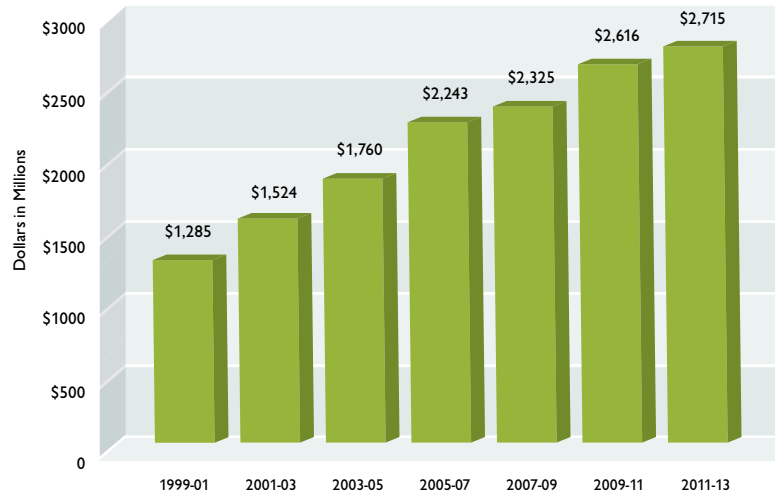
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pay just \$1,476 for family coverage. The cost difference is only slightly higher when comparing Washington state employee costs solely to those of private sector workers. An October 2010 study from the Bureau of Labor Statistics found that, in 2009, the annual average employee share of the flat-rate premium for family coverage was \$4,196, nearly three times the amount paid by state workers in Washington.

In December 2010, labor unions and the governor agreed to increase the employee share of premiums to 15 percent for 2011-13.

WASHINGTON STATE CONTRIBUTIONS FOR STATE EMPLOYEE & K-12 HEALTH CARE BENEFITS



Source: Health Care Authority

While more than the 12 percent employees pay currently, it is significantly lower than the 26 percent the governor had proposed. This cost-sharing structure is also significantly lower than the national norm for both public and private sector employees.

The opportunity cost of failing to capture savings by adjusting the employee share is a larger budget shortfall and reduced spending for priority services like education.

The growth in employee health benefit costs must be addressed. Washington should:

1. Pursue a cost-sharing structure with public employees comparable to the public and private sector norm.

The tentative agreement reached in December 2010 between the governor and state employee unions to increase the employee share of health care premiums from 12 to 15 percent does not go far enough to establish parity with cost-sharing structures in the private or public sectors nationwide. Further, the agreement fails to set the state on a more

sustainable budget path and squeezes out funding for other priorities. An agreement closer to the governor’s original proposal – which increased the employee share of health care premiums to 26 percent – would provide benefits competitive to the private and public sectors and help reduce the state’s structural deficit.

2. Follow through on the 2006 legislative mandate requiring a health savings account/high-deductible health plan (HSA) option for public employees.

Originally planned for implementation by 2009, the Public Employees Benefits Board (PEBB) was not able to move forward with an HSA option because internal systems needed upgrading. PEBB now has the go-ahead and is on track to implement the HSA plan in 2012.

The experience in Indiana demonstrates that HSAs work. Indiana has had an HSA option for state employees for five years. More than 70 percent of employees choose

By giving employees a financial stake in controlling their health care expenses, health savings accounts save money for both state employees and the state.

the plan in lieu of the traditional health care option. Mercer Consulting concluded that the HSA option reduced Indiana's costs by 11 percent. Mercer also found that the total average cost of the consumer-driven health plan (which includes the HSA) was \$5,462 per enrollee, compared to \$12,317 for the traditional plan. Given that Washington is poised to spend \$3 billion on state and K-12 employee health benefits during the 2011-13 biennium, the savings potential is substantial.

By giving employees a financial stake in controlling their health care expenses, HSAs save money for both state employees and the state. (As Governor Gregoire's Blue Ribbon Commission said, "Informed shoppers are smart shoppers.") HSAs also give employees more flexibility and options.

3. Bring K-12 employees into PEBB or require school districts to purchase health care for K-12 employees as a group.

The state allocates funding for public school employee health insurance just as it does for state employees, but school districts do not have to purchase health insurance through PEBB. Thus, most school districts get their insurance separately, through brokers. If the state brought K-12 employees into PEBB, the larger purchasing pool would yield direct financial benefits to the purchasers. Alternatively, the state's school districts should pool together, thereby creating a larger risk pool, standardizing plan design, and significantly increasing their ability to reduce costs.

BASIC HEALTH PLAN

The Basic Health Plan covers residents (through private health plans) who have income below 200 percent of federal income guidelines and who are not eligible for Medicare or Medicaid. The BHP began as a pilot project in 1987 and became a permanent program in 1993. State funds subsidize coverage for these low-income enrollees (who pay a minimum monthly premium of \$34, in addi-

tion to an annual deductible, coinsurance and an out-of-pocket maximum).

Budget constraints led lawmakers to reduce BHP enrollment by 43 percent in the 2009-2011 budget cycle. Enrollment in the previous biennium had reached 107,000. The governor's proposed 2011-13 budget eliminates the BHP altogether. As the BHP enjoys considerable legislative and popular support, there may be attempts to maintain the program. If lawmakers choose to continue a non-Medicaid subsidized health insurance program, they should adopt requirements to target enrollment and improve health care outcomes.

1. Require all BHP enrollees to complete a health assessment.

Currently, the state Health Care Authority (or HCA, the agency which administers BHP) does not require subsidized BHP enrollees to complete a health assessment. (Conversely, by statute, HCA must require applicants for non-subsidized enrollment to complete a health questionnaire.) State law specifies that the "administrator shall encourage enrollees who have been continually enrolled in basic health for a period of one year or more to complete a health risk assessment and participate in programs approved by the administrator that may include wellness, smoking cessation, and chronic disease management programs."

As the Blue Ribbon Commission found, state health care programs should encourage enrollees to take more responsibility for their health, reducing the need for medical interventions. Requiring health assessments, as recommended by the Commission, would allow for improved case management and preventative care, thereby lowering costs and increasing efficiency. If BHP administrators have a better understanding of the health risks clients face, they can better create wellness programs to address them. Many private companies are increasing their use of health assessments as costs rise. The 2010

Health care expenditures can and should be subject to the same budget discipline applied to other areas of state spending.

Kaiser/HRET Employer Health Benefits Survey found that 55 percent of firms with 200 or more workers offer health risk assessments. Of those, 36 percent offer financial incentives to complete the assessment.

2. Tighten eligibility requirements.

Enrollment in the BHP should be limited to those who have no alternatives to publicly subsidized healthcare coverage. Eligibility qualifications should guarantee coverage of those who most need the benefit. In determining eligibility, the program should require disclosure of assets along with income in the application process.

CONCLUSION

The upward trend in health care spending, unsustainable even in periods of robust revenue growth, now represents the single largest threat to Washington's fiscal health. Often treated as uncontrollable, an artifact of entitle-

ment policies that put spending on autopilot, health care expenditures can and should be subject to the same budget discipline applied to other areas of state spending.

Washington must obtain Medicaid waivers to gain program flexibility; pursue a cost-sharing structure with state employees comparable to that of public and private employees nationwide; follow through on a mandate that public employees have the option of an HSA; bring K-12 employees into PEBB or require school districts to purchase health care as a group; and adopt requirements to target enrollment and improve health care outcomes in the BHP (if the program is maintained).

The current budget crisis has brought urgency to health care policy reform. Independent of the state's financial condition, however, these Thrive Washington recommendations will lead to better health care delivery and outcomes, more efficient use of state resources, and a sustainable, priority-based budget.

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