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LESS MONEY, GREATER RISKS FOR STATES UNDER MEDICAID BLOCK-GRANT PROPOSAL

A joint report from CBPP and the Georgetown University Institute for Health Care Research and Policy, *Administration's Medicaid Proposal Would*

The full report can be viewed at
<http://www.cbpp.org/4-1-03health.htm>

Shift Fiscal Risks to States, examines the Administration's proposal to give states a modest increase in funds between 2004 and 2010 to help cover their Medicaid costs during the state fiscal crisis. This offer is an unfavorable deal for states, the report explains. In return for this temporary boost in federal funding, states that accept the offer would have to:

- **Repay the additional funds in later years.**

States that receive the extra federal funds would have to repay them in fiscal years 2011-2013 through a reduction in their federal Medicaid payments. This reduction would come just as state health care costs will begin rising considerably due to the retirement of the baby boom generation.

(Moreover, newly enacted tax-cut legislation provides states with \$10 billion in additional federal Medicaid funds for use in 2003 and 2004, and does so without cutting the federal Medicaid funds provided to states in subsequent years.)

| No Net Increase in Federal Funding Over Ten Years Under Plan | |
|--|---|
| Fiscal year | Change in federal funding compared to current law |
| 2004-2010 | + \$12.7 billion |
| 2011 | - \$150 million |
| 2012 | - \$4.4 billion |
| 2013 | - \$8.3 billion |

In addition, the reduced federal payment levels in 2013 — when federal payments would fall \$8.3 billion below the level projected under current law — would likely serve, when the block grant is renewed, as the starting point for deliberations over the size of the federal block grant for years after 2013.

- **Assume all the risk of greater-than-expected cost increases.** Currently, the federal government and the states share the risks and the burdens of greater-than-anticipated increases in Medicaid enrollment and health care costs. The federal government is committed to paying a certain percentage of each state's Medicaid costs, so federal payments rise automatically as state costs increase.

The Administration proposal would end this federal commitment. Under the proposal, states that receive extra federal funds would have to transform their Medicaid and SCHIP programs into a capped block grant, which would provide states with a fixed amount of Medicaid funds each year regardless of the extent of their cost increases. The size of the block grant would rise each year under a formula that has yet to be determined but that apparently would be based on *current* projections of *future* costs. These annual increases in funding would likely fall short of fully reflecting the cost increases that states actually incurred, since Medicaid costs are extremely difficult to forecast accurately. For example, the Congressional Budget Office's 1998 projections for federal Medicaid spending five years hence (i.e., in 2002) turned out to be 12 percent, or \$17 billion, below

actual expenditures.

The difficulty of forecasting Medicaid costs stems from the large number of hard-to-predict factors that affect them, including the state of the economy, trends in employer-based health coverage, the price of health care services, the outbreak of an epidemic or the onset of new diseases, advances in medical technology, demographic changes, and changes in poverty rates. A block grant would absolve the federal government of any risk or responsibility related to greater-than-expected increases in Medicaid costs resulting from these or other factors, with states having to bear such cost increases without any federal contribution.

- **Bear the full cost of any future improvements in health coverage.** Currently, states can obtain matching federal Medicaid funds to help finance initiatives to reduce the ranks of the uninsured or meet other unmet health needs. In this way, the federal government and the states share the burden of paying for improvements in health care.

This relationship would end under the block-grant proposal. While states would be free to expand coverage, they would receive *no* new federal funds to help pay for it; instead, states would have to finance the full cost of these improvements by using state funds, reducing coverage or benefits for current Medicaid and SCHIP beneficiaries, or cutting payments to providers, which already are lower in Medicaid than in other health insurance programs. Thus, the block grant would reduce states' ability to improve their Medicaid programs.

- **Give up a critical element of flexibility in the current program.** A block grant would eliminate what is perhaps Medicaid's most important element of flexibility for states: the funding mechanism under which states can count on the federal government to bear its share of unanticipated costs and program improvements. (It also would end the federal government's commitment to bear its share in the years ahead of the burgeoning costs of long-term care and other health care services for an aging population.) This flexible financing mechanism would be replaced by an inflexible cap on federal Medicaid funding.

States Could Be Forced to Make Cuts That Harm Vulnerable Populations

Under the Administration plan, states that accept capped federal payments would be given more control over their Medicaid programs, but they would likely have substantial difficulty achieving sufficient savings to offset the probable loss of federal funds. States already have considerable flexibility (and financial incentive) to undertake cost-containment initiatives. Moreover, 83 percent of the Medicaid expenditures that fall into the categories that states would be allowed to cut under the proposed block grant goes for services for elderly or disabled beneficiaries, which generally are difficult for states to cut. Finally, research indicates that various measures that might achieve significant savings, such as capping enrollment or imposing high premiums or other significant charges on beneficiaries, could seriously impede access to necessary care.

States' need for fiscal relief, the report concludes, should be met by measures that help states contain health costs in effective and responsible ways while making resources available to help them maintain health coverage for their residents. The Administration's block-grant proposal does not meet this test.