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February 12, 2003

The Bush Administration's Medicaid Proposal Would Shift Risks And Costs To States

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The Bush Administration's fiscal year 2004 budget proposal appears to provide a small amount of funding to help states meet Medicaid costs during this time of state fiscal crisis. This possibility of fiscal relief, however, comes with a catch. The proposal makes unprecedented changes to federal financing of the Medicaid program that would shift future risks and costs to the states.

Any state that chooses to receive the offered assistance with Medicaid costs now could pay a steep price in the future. A state receiving these funds would have to:

- Repay the funds in future years, and
- Agree to transform its Medicaid and State Children's Health Insurance Program (SCHIP) into a capped, consolidated, block grant.

A state accepting the up-front fiscal assistance would no longer receive federal Medicaid matching funds that grow automatically in proportion to caseloads and health care costs.

Health care costs and utilization are expected to rise rapidly overall as the nation's population ages. In addition, a range of factors can cause Medicaid costs to rise rapidly at particular times in particular states; these factors include swings in the economy, state population growth, an influx of older residents, an epidemic, or a natural disaster. A block grant with a specified, capped growth rate based on a state's 2002 spending would not take account of such circumstances. It is likely to leave many states with less federal funds than they need to meet their health care costs, even during the next seven years when federal funding is said to be increased modestly.

Moreover, the budget shows that states would receive $150 million less in federal Medicaid funding in 2011 than they would be projected to receive under current law, $4.4 billion less in 2012, and $8.3 billion less in 2013. There is little reason to believe that states could absorb such cuts at that time, when the baby boom generation will already have begun to retire and require more benefits and services. Administration documents are silent as to whether federal funding would continue to ratchet down in years subsequent to 2013.

States that decline this offer to block grant their programs would be denied federal fiscal relief during this time of severe budget deficits.

Few specific details of the proposal have been made available. However, based on the broad outline the Administration has provided, significant concerns regarding the long-term fiscal impact on states that take up this option are evident.

The fiscal relief in the proposal is a "loan" and not a grant. The Administration's fiscal year 2004 budget estimates an increase of $3.25 billion in additional Medicaid funds in fiscal year 2004 and a total of $12.7 billion over the subsequent seven years. According to statements and documents provided by the Department of Health and Human Services, these funds would be distributed *only* among states that agreed to shift their Medicaid financing structures from an open ended entitlement to a block grant.[1]

Unlike the various Congressional fiscal relief proposals that would temporarily increase states' Medicaid match rates during the current economic downturn, the Administration's plan would require states to repay the funds during years 8, 9 and 10 of the 10-year budget window at which time, as noted, federal funding for Medicaid would decline sharply.

States must place themselves in a long-term fiscal straitjacket to qualify for the Administration's short-term loan. In order to receive aid now, the Administration's plan requires that states give up the current financing protection that is inherent in the Medicaid program. Under current rules, when enrollment or costs rise, federal Medicaid matching funding increases automatically. This critical component of the Medicaid financing structure would end in states that entered into a block grant arrangement.

The Administration's proposal suggests that the block grants to states will be adjusted annually based on an unspecified national trend rate, and that a modest amount of funds in addition to the projected costs under the trend rate — $12.7 billion — will be provided over the next seven years. Full details of this provision have not been disclosed. However, no trend rate adjustment can automatically keep pace with health care costs if, for example, there is a recession that makes more people eligible for Medicaid, a sharp increase in the price of prescription drugs, or significant advances in medical technology or treatments that improve health or save lives but increase health care costs.

In addition, the block grant would be based on each state's 2002 spending. This would give an advantage to states that currently have more comprehensive Medicaid programs over those that might have wished to expand coverage in the future. The block grant also is likely to fail to account adequately for the different rates of growth over time of health care costs in specific states. For example, some states may have higher population growth than others. The elderly population, which is costly to serve under Medicaid, may be growing more rapidly in some states than in others. Some states may be hit with a local or regional economic downturn, a natural disaster, or an epidemic that causes Medicaid rolls to expand. The block grant is highly unlikely to appropriately compensate states for such costs.

[1] The Administration's proposal does not provide specific information regarding the formula that would be used to determine the distribution of these funds. Additionally, it is unclear whether the $3.25 billion is a fixed dollar amount to be divided among all states that choose to block grant their programs in 2004, or if it is an estimated amount based on the Administration's currently undisclosed block formula and the number of states it assumes will take up the option. Questions regarding whether states must take up the option by a date certain in order to receive these funds also remain unanswered.

Moreover, the Administration's plan requires that states continue to cover comprehensive health care services for mandatory beneficiaries with the block grant funds, even if the cost for the mandatory beneficiaries is rising at a much more rapid rate than the block grant funding.

In any of these situations — unlike under current law — states would have to pay from their own funds for *all* of programmatic costs that exceed the level of their block grants.

The Administration anticipates that states will react to reduced funding by serving fewer people or providing less benefits. If a state could not cover the health care costs that exceed its block grant allotment, the block grant would give it flexibility to reduce or eliminate coverage and services for the "optional beneficiaries" currently served under their Medicaid and SCHIP programs. The flexibility would include the ability to offer minimal insurance instead of a comprehensive Medicaid benefit, and to charge high co-payments for services. These optional populations include children and families, seniors and people with disabilities. About one-third of current Medicaid beneficiaries — an estimated 14 million individuals — belong to optional groups. They include an estimated 4.7 million children, 4.5 million pregnant women and working parents, 3 million elderly, and 1.8 million people with disabilities. Nearly three-fifths of elderly Medicaid beneficiaries belong to an optional group.

While the Administration plan proposes to preserve comprehensive benefits for mandatory groups, it is unclear whether the actual benefits provided to these beneficiaries would mirror their current coverage or if important rules regarding cost sharing and patient protections could be relaxed.

The Administration would effectively end the State Children's Health Insurance Program, terminating the federal government's promise to provide a dedicated funding stream to help states to increase health care coverage for children. The Administration's plan would require states to merge their SCHIP funds into their Medicaid block grants. As the baby boom generation ages, long term care utilization increases, and the cost of prescription drugs continues to rise at double digit rates, it is likely that states will have to choose between using their fixed funds to cover seniors and people with disabilities and providing for the health care needs of children in low-income working families.

Today, states face their worst budget shortfalls since World War II. Many are currently being forced to make cuts in their Medicaid programs. Several bipartisan bills in both the House of Representatives and the Senate have been introduced supporting the notion of temporary state fiscal relief. For example, bipartisan proposals offered in the House and Senate would increase federal Medicaid matching funds by $10 billion this fiscal year -- as compared to $3.25 billion in the FY 2004 in the Administration's proposal -- and would thereby begin to immediately lower states' expenditures by that amount. None of these proposals require a repayment. Moreover, none of these genuine fiscal relief proposals require states to make permanent changes in the structure of their Medicaid programs that last for years and years after the fiscal relief ends.

By contrast, the Bush Administration Medicaid proposal offers a "bait and switch" scheme to states — providing states with a loan and some additional programmatic flexibility in the short-term, while leaving states holding the bag for financing their Medicaid and SCHIP programs over the long run.