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ADMINISTRATION'S REGULATION TO REDUCE MEDICAID "UPPER PAYMENT LIMIT" WOULD FURTHER WORSEN STATE BUDGET CRISES

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The Administration has issued a proposed regulation to lower the Medicaid "upper payment limit" (UPL) for public hospitals. This regulation would limit how much states could reimburse such hospitals, which would have the effect of reducing federal Medicaid matching payments to a number of states. Because the Administration wants to implement this change in the very near future, states would find their federal Medicaid matching funds reduced during the recession. This would worsen the budget deficits that states face this fiscal year — which are expected to exceed \$35 billion and may reach \$50 billion, according to the National Governors Association — and force states to cut program expenditures or raise taxes to an even greater degree than they already will have to do to balance their budgets.

The Administration argues that states are abusing the "upper payment limit" rules by using these rules as a mechanism to secure funds from the federal government that are not provided to hospitals but instead are used elsewhere in state budgets. This is true in part. Some of these funds are being siphoned off for other purposes. But it also is true that a significant share of these funds are used to support local public hospitals. The hospitals that receive this assistance generally serve substantial numbers of uninsured patients, including individuals who have recently become unemployed. Moreover, as a result of the recession, safety-net hospitals are likely to be caring for even more uninsured and low-income patients in coming months. The finances of some of these hospitals could be jeopardized by the imminent change in UPL policy.

The Administration's efforts to change this rule *now* are ill-advised. If a change is to be made in these rules and federal UPL payments to states are to be reduced, *it should not be done while the economy is in recession and states face gaping budget deficits*. Indeed, although the fact that some of these funds are siphoned off for use elsewhere in state budgets is a serious problem that warrants redress in normal years, in a recession such action lessens the degree to which states must cut other expenditures or raise taxes. State actions to cut expenditures or raise taxes during a recession further dampen economic activity and thereby aggravate the downturn. Furthermore, there is a need during recessions for an increase in federal funding to states to serve uninsured patients, not a decrease in such funding.

After the downturn is over, a tightening of the UPL rule would be in order if it is done as part of an effort to increase the effectiveness of federal health care spending in reducing the ranks of the uninsured — that is, if the savings the federal government realized from cutting UPL payments to states were used to provide added funding to states to reduce the number of uninsured in a manner not susceptible to diversion of these funds for other purposes. This is not the case, however, with the proposed UPL regulation the Administration has issued. None of the

savings from that regulation would be rechanneled for such purposes. (Instead, the savings would apparently be used to narrow future budget deficits and ease pressure on elements of the tax cut not yet in effect.)

- On November 23, the Centers for Medicare and Medicaid Services (CMS) released a proposed regulation to lower the maximum amount (or “upper payment limit”) that states may pay local government-owned hospitals through Medicaid. The proposed regulation would reduce UPL payments for these hospitals by up to one-third. CMS intends to issue the final regulation very soon and expects it to be effective as soon as February 2002.
- The Administration has claimed the upper payment limit should be lowered because almost none of the UPL payments actually are aiding safety net hospitals. The Administration has claimed that states are diverting nearly all of these funds for other purposes. A number of public hospitals, however, maintain that they rely on UPL funds to bolster their ability to provide uncompensated care to the uninsured. While there is little recent or substantial data and state practices vary, evidence from a review of a number of states by the HHS Office of the Inspector General and the Urban Institute does indicate that safety net hospitals retain UPL payments to a significant extent. In two of the three states reviewed, the Office of Inspector General found that at least two-thirds of UPL payments remained with the public hospitals.
- The National Governors Association estimates that states now face budget shortfalls of more than \$35 billion for the current fiscal year and that when the increased homeland security costs that states will bear are taken into account, the shortfalls reach \$40 billion. NGA also warns that if the unemployment rate reaches 6.5 percent, as it very well may, state deficits could reach \$50 billion. Since states must balance their budgets even in recessions, states now are planning or instituting large budget cuts as well as some tax increases. Such austerity measures, however, further weaken the economy. Accordingly, states need fiscal relief from the federal government to help them close these budget deficits.

Lowering the UPL *now* goes in the opposite direction — it would make state budget shortfalls larger rather than smaller. It would have the counterproductive effect of causing a number of states either to raise taxes or to cut program expenditures — including expenditures for Medicaid — to a greater extent than they already will have to do.

- This proposal overrides an agreement to curb UPL payments negotiated with Congress just last December as part of the Benefit Improvements and Protection Act of 2000 and reflected in regulations that took effect in March. Those reforms

will reduce Medicaid expenditures by \$77 billion from 2001 to 2010, according to the Congressional Budget Office. The Administration's new regulatory proposal would go beyond those reforms to further reduce UPL payments to hospitals, which would be a very unwise course at this time.

- CBO has estimated that the proposed regulation, which was contained in the President's budget proposal for 2002, would lower federal payments to states by about \$700 million in FY 2002 and \$900 million in FY 2003. The Administration's estimate is slightly higher (\$800 million in 2002 and \$1.3 billion in 2003).
- The Administration's issuance of the proposed UPL regulation already has had some negative effects. The state of Indiana has announced it will cancel a recently enacted expansion of Medicaid coverage for 42,000 parents with incomes below the poverty line — a number of whom are recently unemployed — because the proposed UPL regulation would reduce Medicaid funding to the state.
- Nearly 30 states currently have, or have applied for, a hospital-related UPL plan and would lose federal funds. (Other states are considering UPL plans and could be affected.) The states that now have UPL plans are: Alabama, Alaska, Arkansas, California, Florida, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Jersey, New Mexico, North Carolina, Ohio, Oregon, South Carolina and Washington. Other states that have submitted UPL plans include: Colorado, Idaho, Iowa, Kentucky, Minnesota, Nebraska, New York, and Texas.
- Michigan and Montana have existing UPL plans but also have submitted plan amendments to modify and presumably widen their current arrangements, based on the existing regulations. Iowa recently submitted an application.
- The great majority of these states would be affected as soon as the final regulation is effective and would receive less federal funding this fiscal year.
- There are both Senate and House proposals to impose a temporary moratorium on either the implementation or issuance of the regulation. The cost of a one-year moratorium is about \$50 million. (The CBO "score" is less than the federal cost of UPL payments to states, because CBO considers the likelihood that the regulation will be made final as one element of its cost estimates. CBO currently views the likelihood of implementation in the near term as low because of anticipated Congressional opposition, so the cost of a legislative moratorium is relatively small.)

At a later time, it would be appropriate to reassess Medicaid UPL policy and determine the actual extent to which the existing payments are being used to support health care or are being diverted for other purposes. This, however, is the wrong time for a regulation reducing UPL payments, as it would reduce funding to states and thereby force them to raise taxes or cut program spending to a greater degree during a downturn. If UPL policy is revised later, any resulting savings should be used to expand health insurance coverage or strengthen the health care safety net.