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NGA MEDICAID TASK FORCE'S DRAFT PROPOSAL SHIFTS FISCAL RISKS TO STATES AND JEOPARDIZES HEALTH COVERAGE FOR MILLIONS

Draft Offers Little Improvement over Flawed Administration Approach

By Edwin Park, Cindy Mann, Joan Alker, and Melanie Nathanson¹

Members of the National Governors Association Medicaid Reform Task Force are developing a draft proposal to fundamentally restructure the Medicaid program which they may shortly circulate to other governors.² The draft proposal is similar in its basic approach to the Bush Administration's Medicaid reform proposal that the governors declined to endorse at their winter meeting in February.³ In withholding support for the Administration proposal, the NGA cited the lack of detail and expressed substantial concerns about a central element of the Administration's plan — the provision to replace the current open-ended federal financing system with capped federal payments. The NGA subsequently convened a bipartisan Medicaid Reform Task Force of ten governors to consider the issue of Medicaid reform. The major differences between the Administration's proposal and the NGA Task Force draft reflect concerted efforts by the governors to protect states from the fiscal risks posed by a cap on federal Medicaid funding. The changes included in the Task Force draft proposal, however, are likely to be of limited benefit in protecting states from bearing significant new fiscal burdens, both because some of the changes are not likely to be effective and because the changes are highly unlikely to be adopted by Congress in the way the Task Force has designed them.

Like the Administration proposal, the Task Force draft proposal would substitute capped federal Medicaid payments for the current open-ended financing system in which the federal government shares fully in all state Medicaid costs. Capped payments (for those states that elected to take them) would apply to all spending for the groups of people and the benefits that states are not *required* to cover by federal law; this so-called "optional" spending currently accounts for about two-thirds of all Medicaid costs. If these capped payments do not keep pace

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² As of this date, the NGA had not determined whether the final policy will be presented for a 2/3 vote to all governors, the NGA Executive Committee, or to just the ten members of the Medicaid Reform Task Force.

³ For a comprehensive analysis of the Administration's Medicaid reform proposal, see Cindy Mann, Melanie Nathanson and Edwin Park, *Administration's Medicaid Proposal Would Shift Fiscal Risks to States*, Center on Budget and Policy Priorities, Revised April 22, 2003. See also Jocelyn Guyer, *Bush Administration Medicaid/SCHIP Proposal*, Kaiser Commission on Medicaid and the Uninsured, May 2003; and John Holahan and Alan Weil, *Block Grants Are the Wrong Prescription for Medicaid*, Urban Institute, May 27, 2003.

with increases in health care costs and enrollment, federal funding to states would decline over time compared to what states would receive under current law, and states would bear greater financial risk. In addition, under a capped payment system, states would not receive additional federal funding for program expansions and improvements states might undertake when their economies improve to cover more of the uninsured. (Currently, if a state commits its own funds to expand or improve coverage under Medicaid, the federal government automatically pays for 50 to 77 percent of the cost, depending on the state.)

Under the NGA Task Force draft, in exchange for states accepting capped federal payments for about two-thirds of their Medicaid programs, states would receive significantly greater flexibility to revise or eliminate many current federal standards and requirements, including safeguards for beneficiaries related to eligibility rules, benefit packages, and limits on cost-sharing. For example, states would gain flexibility to cap enrollment and initiate waiting lists, to scale back or drop hospital, mental health or drug coverage for adults (including people with disabilities or chronic illnesses), or to charge low-income families substantially higher cost-sharing amounts.

Unlike the Administration's proposal, under the Task Force draft proposal, the federal government would also fully assume the costs of providing prescription drugs, long term care and other services to low-income Medicare beneficiaries who are also enrolled in Medicaid. (These beneficiaries are often referred to as "dual eligibles.") Some governors may be predicated support of a cap on a complete federal takeover of the costs of care for dual eligibles. They believe that the resulting financial benefits would outweigh the fiscal risks posed by capping Medicaid funding. Considering the significantly constrained federal fiscal environment, however, it is highly unlikely that such a full takeover could be enacted.

In 2002, Medicaid provided essential health coverage and long term care services to more than 50 million people, including over 25 million children, eight million people with disabilities, and nearly five million seniors. It pays for about 40 percent of all births in the nation and is the single largest source of funding for nursing home care. Moreover, hospitals, doctors, community clinics, pharmacies and other providers throughout the nation rely on Medicaid payments, which account for about 17 percent of all health care spending. The fundamental changes reflected in the NGA Task Force draft proposal would have a deep and lasting fiscal impact on states. As explained below, these changes could jeopardize access to health care for millions of Americans now insured through Medicaid.

Urban Institute Analysts Highlight Flaws of Converting Medicaid to a Block Grant

On May 27, the Urban Institute issued a study analyzing the cap of Medicaid funding, as under the Administration's Medicaid proposal, and its consequences for states, beneficiaries, and health insurance coverage.* The study was authored by John Holahan, the Director of the Health Policy Center at the Urban Institute, and Alan Weil, the Director of the Institute's *Assessing the New Federalism* Project and former Medicaid director for the state of Colorado. The analysis outlines several key concerns with a proposal that would cap federal Medicaid funding and effectively convert Medicaid to a block grant:

- Capped Medicaid funding or block grants would make Medicaid far less responsive during economic downturns. Medicaid enrollment generally increases in bad times, even as state revenue collections fall. "In fact, the current fiscal structure makes Medicaid a countercyclical program, with the federal government spending more when the economy is weak." With a funding cap, "when the economy weakens, federal funds will not increase and states, facing fiscal pressures, are likely to cut spending."
- "Shifting risks to states is placing the risk at the level of government less able to absorb it." States have narrower tax bases and less diverse economies than does the federal government, and are more subject to volatile changes in their revenue collections. States, as a result, would be unable to sustain their Medicaid programs even when they are most needed.
- Block grants or funding caps would stifle states' innovation in their Medicaid programs. This is because caps "lock states in where they are at the outset and take away the primary tool they need to make changes: money." States often experiment with their programs and may expand coverage to more of the uninsured. Without additional federal funds being made available to help defray the cost of such changes, however, states would likely be unable to afford them. Moreover, states would become wary of making any major policy changes. Such changes "are precisely the sort of risk states are likely to avoid to provide themselves with some stability in an increasingly uncertain fiscal position."
- The expanded flexibility provided to states under a block grant is not expected to yield substantial savings that could offset some of the fiscal risks that caps pose. Taking into account the poorer health of Medicaid beneficiaries, spending per enrollee is already lower under Medicaid than under private insurance, leaving little room to capture further savings. States could scale back benefits but an "examination of optional benefits under Medicaid reveals relatively few realistic opportunities for saving money." Certain acute care services like vision and dental care could be cut, but these services account for only seven percent of Medicaid spending. Similarly, cost-sharing could be increased substantially but greater cost-sharing can "also deter necessary care, defeating the purpose of coverage." Finally, states could impose enrollment caps and waiting lists, but states can already reduce eligibility levels to scale back enrollment. Moreover, enrollment caps are "arbitrary and affect potential beneficiaries regardless of income or health status."
- Overall, under a block grant, "states are less likely to expand coverage and more likely to make large cuts in difficult times." The study concludes, "if meeting the health care needs of the poor and the sick is a national priority, the federal government's role must remain larger than writing checks to states. Converting Medicaid into a block grant moves health policy in the wrong direction."

* John Holahan and Alan Weil, *Block Grants Are the Wrong Prescription for Medicaid*, Urban Institute, May 27, 2003.

NGA Task Force Proposal Still Shifts Financial Risks to States

Under the Administration’s proposal, the federal government’s liability for Medicaid costs in states that voluntarily participate in the new program would be capped over the next ten years. The capped federal funds would be allotted to individual states based on either a pre-set formula or state-specific negotiations. Federal funding would no longer be open-ended and automatically adjust to reflect actual state costs, but rather would be based on current projections of Medicaid costs over the next 10 years. Medicaid costs, however, are notoriously difficult to predict because of the myriad factors that drive Medicaid spending. These factors include changes in the economy, shifts in the size and demographics of a state’s population, developments in medical technology, changes in the private health care marketplace, and the outbreak of an epidemic or the onset of new diseases.

The Task Force draft proposal tries to address states’ significant concerns over the risks that placing a cap on federal funding would pose by allowing the capped allotments to be adjusted upward when certain conditions are met. Task Force documents cite increases in unemployment rates, natural disasters, and the introduction of new technologies as possible triggers for these adjustments. In addition, states could seek to renegotiate the level of capped funding they receive every 3-5 years if the capped amount proved insufficient for other reasons. The proposal also builds in access to additional but undefined “stop-loss” federal funding — perhaps an increase in federal funding triggered when state costs exceed the cap by a certain threshold — which would be available to states as another financial protection.

These protections, however, are likely to be inadequate to shield states from substantial financial risk for several reasons.

- **As with the formula for setting the capped amounts themselves, no adjustment formula can accurately predict or deliver the level of federal funding a state might actually require over time.** Any formula would need to specify certain triggers for a funding increase; states affected by factors increasing Medicaid costs that are not among the enumerated triggers would not get additional funding. Furthermore, no formula could provide the same level of funding as under the current federal financial entitlement structure. Even if a state could qualify for additional funding under the adjustment formula, there is no guarantee that states would receive adequate adjustment amounts that come close to what they would receive under current law. If no precise formula or set of factors were used to trigger adjustments, and states were able to simply “make their case” periodically to the federal government for additional payments through a negotiation process, the adjustments could be approved and allocated in arbitrary and perhaps politically-motivated ways.⁴

⁴ Under the Administration’s “Pharmacy Plus” waivers, states are permitted to extend a prescription drug-only Medicaid benefit to additional low-income elderly individuals. Under these waivers, however, states must ensure that federal spending is not greater than the spending that would have otherwise occurred without the waiver. Growth rates approved by the federal government to ensure budget neutrality have varied significantly among the

- **Any adjustment made pursuant to a formula would likely be too little too late.** Adjustments would be provided *subsequent* to the occurrence of events that increased Medicaid spending unexpectedly. For example, a national recession may quickly drive up a state’s Medicaid costs as families lose their jobs and health insurance and become eligible for Medicaid. A funding adjustment relying on economic trends, however, would likely be furnished some time after the state was forced to absorb substantial Medicaid costs (perhaps not until the state receives its capped allotment for the next fiscal year). An added problem is that there are not readily available state-based data for many of the factors for which upward adjustments may be appropriate. For example, there are no accurate, timely data sources on a state level showing how private sector health insurance premium costs are changing. Yet such costs affect Medicaid spending in many ways. Higher insurance premiums for businesses that cause firms to drop coverage for their workers shift more responsibility and costs onto Medicaid. As a comparison, the current Medicaid financing system provides additional federal funds immediately, as people’s needs and states’ Medicaid costs rise.
- **More importantly, it is likely that open-ended adjustment factors could *not* be included in a Medicaid reform proposal under Congress’ current budget rules.** The Congressional budget resolution that Congress adopted in April provides that any Medicaid reform proposal enacted by Congress must be “budget-neutral”; that is, it must not increase federal Medicaid spending above the levels currently projected over the next 10 years. In addition, the Administration has clearly indicated that it will not accept a Medicaid reform proposal unless it is budget neutral. Unlike the fixed, enforceable caps on Medicaid funding that the Administration’s proposal contemplated, the more flexible caps in the Task Force draft proposal that provide for open-ended upward adjustments are not likely to be determined by the Congressional Budget Office to be budget neutral over the ten-year budget window.
- **The proposed adjustments, even if included, would need to be capped themselves to conform to the budget neutrality requirement.** Adjustments that increase funding could be built into a Medicaid reform proposal, but only if the adjustments, like the underlying capped state allotments themselves, were made to fit within an overall cap on federal Medicaid funding. This could be accomplished by reducing — and holding back in reserve — the capped Medicaid allotments that otherwise would be made available to states and allocating the reserved funds to qualifying states according to whatever formula or adjustment factors are adopted. All states would essentially contribute to the fund. There could be no guarantee that the reserve fund would be adequate or that all states that qualified for an adjustment would actually receive funds (or receive sufficient amounts).

four states with approved waivers, without any apparent basis in terms of the states’ historic or projected growth rates. Jocelyn Guyer, *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps*, Kaiser Commission on Medicaid and the Uninsured, May 2003.

If states are not adequately protected from the financial risks that imposition of caps on their Medicaid funding would pose, federal funding over time would fail to keep pace with increases in health care costs and enrollment and would fall short of what states would have received under current law. If this occurs, states will either have to pay the additional costs entirely from state funds or roll back eligibility or benefits or cut provider payment rates. While states would have significantly greater flexibility to change the rules for many beneficiaries and services under the Task Force draft proposal, according to analysts at the Urban Institute, it is unlikely this flexibility would lead to sufficient savings unless a state took steps to reduce coverage or services significantly.⁵ Moreover, states would receive no new federal funds to finance expansions or other improvements to reach more of the uninsured. Improvements would have to be offset by cuts in benefits or eligibility for current beneficiaries, or financed entirely with state dollars. As a consequence, states would have less ability under capped funding to address unmet health care needs and reduce the ranks of the uninsured than they possess under the current financing system.

Full Federal Assumption of “Dual Eligible” Costs Is Unlikely

The NGA Task Force draft premises much of its support for capped Medicaid funding on the federal government picking up the full cost of the services that state Medicaid programs now provide to low-income Medicare beneficiaries. Some governors could believe that the financial risks of capped funding, as discussed above, are outweighed by the fiscal benefits resulting from a complete federal takeover of these costs. The problem, however, is that a full federal assumption of these costs is near-impossible in the current fiscal environment. Instead, it is very likely that such a provision would be immediately dropped if and when Congress begins consideration of the Task Force proposal. At best, if Congress could provide any federal assumption of dual eligible costs at this time, it would likely be of highly limited scope.

Currently, states incur significant Medicaid costs by providing prescription drug and long-term care benefits and subsidizing Medicare premiums, deductibles and cost-sharing for these so-called “dual eligibles.” About 35 percent of Medicaid expenditures are for services provided to dual eligibles. The NGA Task Force draft proposal seeks a Medicare expansion in which all such costs would be paid through Medicare, which is 100 percent federally funded.

There can be little dispute that state Medicaid programs are bearing an increasing financial burden by having to take care of gaps in Medicare, namely the absence of prescription drug and long-term care benefits under Medicare.⁶ But however appropriate such a federal takeover would be, it would raise federal costs substantially above both the federal spending levels currently projected for Medicaid or Medicare and the expenditure levels permitted under

⁵ See Holahan and Weil.

⁶ In 1998, Medicaid paid 35 percent of the total public program expenditures on behalf of seniors and people with disabilities (Medicare paid 65 percent). That percentage is expected to rise to 45 percent by 2012. See Leighton Ku, *The Medicare and Medicaid Link: State Medicaid Programs Are Shouldering a Greater Share of the Costs of Care for Seniors and People with Disabilities*, Center on Budget and Policy Priorities, February 25, 2003.

the Congressional budget resolution. It thus has little chance of winning either Congressional or the Administration's approval. As the *Washington Post* reported on June 3, "the top administration official who oversees Medicaid and Medicare, Thomas A. Scully, yesterday balked at the federal government's absorbing the full cost of patients eligible for both programs, saying, 'that's a massive cost to the federal government.'"⁷

Informal estimates indicate that a federal assumption of just the cost of providing drugs for dual eligibles is somewhere in the vicinity of \$100 billion over ten years. Federal assumption of the costs of all health services that Medicaid now provides for dual eligibles could cost somewhere in the vicinity of at least \$500 billion and most likely, significantly more over ten years. The Congressional budget resolution only allows \$400 billion in new federal spending over the next ten years for the *entire Medicare prescription drug proposal*. It is highly unlikely, given Congress' commitment to provide a drug benefit to Medicare beneficiaries, that Congress would devote one-fourth of this limited funding to buy out states' current contributions for drug coverage for low-income Medicare beneficiaries. In the existing fiscal environment, it is inconceivable that the current Congress would even consider a full takeover of the costs of all Medicaid services for the dual eligibles. (To do so, Congress would have to agree to pass substantial tax increases or large budget cuts in an extensive array of programs.)

Conclusion

The key differences between the Task Force draft proposal and the Administration's proposal are the federal takeover of costs related to dual eligibles and the inclusion of uncapped financial protections and adjustments alongside the capped allotments. Both provisions are intended to offset the fiscal risks that capped federal funding poses. Given the current fiscal constraints under which Congress is operating, however, neither of these components is likely to be included in any federal Medicaid reform legislation. This would leave remaining a fixed cap on federal Medicaid funding similar to that under the Administration's proposal. This limit on Medicaid funding would allow the federal government to scale back substantially its financial responsibility for and commitment to health care for the most vulnerable Americans.⁸

Governors desirous of making improvements to the Medicaid program need not subject themselves to these federal funding caps. Doing so would shift substantial financial risk to states. With rising health care costs and an aging population, the draft NGA Task Force proposal, after being modified by Congress, would be likely ultimately to place many states in a financial bind and to add to the ranks of the uninsured and underinsured.

⁷ Amy Goldstein, "Governors Finalizing Proposal to Revamp Medicaid," *Washington Post*, June 3, 2003.

⁸ Under both the Administration's proposal and the Task Force's draft proposal, states could opt-out of the block grant structure. It could prove difficult, however, for some states to stay out of the new system. The Administration could place pressure on states to participate by providing incentives — and disincentives, such as delaying consideration, approval and renewal of pending waivers and state plan amendments — in order to push more states into the new structure and thereby to place more federal Medicaid funding under a cap.