Center on Budget and Policy Priorities

820 First Street, NE
Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

NEWS RELEASE

For Immediate Release
Monday, February 14, 2006

Michelle Bazie Contact
202-408-1080, bazie@cbpp.org

ADMINISTRATION'S BUDGET WOULD CUT FEDERAL MEDICAID COSTS BY SHIFTING COSTS TO STATES

More than four-fifths of the Medicaid savings proposals in the Administration's new budget would reduce federal Medicaid expenditures by shifting costs directly to the states, according to a new report from the Center on Budget and Policy Priorities. The proposals would save the federal government $35 billion over the next decade, most of which would represent new costs for states. That likely would lead some states to scale back their Medicaid programs significantly by restricting eligibility and reducing coverage.

In reducing federal expenditures at states' expense, these proposals are consistent with the Administration's proposed cuts in grants to state and local governments for programs other than Medicaid. Federal non-Medicaid grants, which declined by roughly $7 billion in 2006 (after adjusting for inflation), would decline by another $7 billion in 2007. The Medicaid proposals also are consistent with the recently enacted budget reconciliation law, which reduces federal spending by $39 billion but would raise state costs by an estimated $5 billion, according to the Congressional Budget Office.

"Most of the Administration's Medicaid proposals don't represent true 'savings' in that they don't reduce health-care costs; they simply shift costs from the federal government to the states," said Andy Schneider, a Medicaid expert and the report's lead author. "Cost-shifting doesn't make Medicaid more efficient — it just passes the buck to the states."

Bulk of Proposed Cuts Do Not Require Congressional Approval

Roughly $30 billion of the Administration's proposed reductions in federal Medicaid expenditures over the next ten years would come through regulatory changes, which do not require congressional approval. Virtually all (98 percent) of these regulatory changes would shift costs to states. They include:

- limiting Medicaid payments to state and local hospitals to help cover the cost of serving uninsured patients;
- eliminating Medicaid payments to help cover administrative and transportation costs associated with treating children with disabilities who are covered by the Individuals with Disabilities Education Act;
- eliminating Medicaid payments to help cover the cost of certain kinds of rehabilitation services, such as therapy and special instruction for individuals with mental illness and developmental disabilities; and
- reducing the amount of taxes states may impose on hospitals and other health-care providers to help pay the state share of Medicaid costs.

The remaining $5 billion of the Administration's proposed federal Medicaid reductions are legislative changes that would require congressional approval. The largest of these changes are cuts in federal funding for targeted case management services (which help specific groups of beneficiaries, such as pregnant women, receive necessary medical care and other services) and for state administrative costs.

A few of the Administration's proposals would reduce state as well as federal costs. Under the new budget reconciliation law, for example, Medicaid payments to pharmacists for multiple-source drugs (drugs marketed or sold by three or more companies) may not exceed 250 percent of the drug's "average manufacturer price." The Administration proposes reducing this limit to 150 percent of the average manufacturer price. However, the modest savings that states would achieve from these proposals would be swamped by the added costs states would face as a result of the Administration's cost-shifting proposals.

Cost-Shifting Could Lead to Less Health Care, Higher Costs for Low-Income Beneficiaries

Although states are no longer in fiscal crisis, many continue to have trouble financing their share of Medicaid costs, largely because of rising health-care costs throughout the economy and the aging of the population. Many states also are incurring substantial costs in providing temporary drug coverage to low-income people who are supposed to be receiving prescription drugs at low cost through the new Medicare drug benefit but have been unable to do so because of problems in implementing the benefit. The Administration's budget includes no funds to reimburse states for these unexpected Medicare-related costs.

The Administration's proposal to shift large Medicaid costs to states would significantly intensify the squeeze on state Medicaid programs — and state budgets. States would not be able to offset these cost shifts through greater program efficiencies such as reducing fraud and abuse; the amounts involved are much too large. Instead, states' options for reducing their Medicaid costs significantly would include limiting eligibility (thereby denying coverage to various people who are both low-income and uninsured), reducing benefits (thereby eliminating coverage for certain health-care services or requiring low-income beneficiaries to pay more for them), or reducing payment rates to health-care providers.

Faced with fiscal pressure from federal cost-shifting, many states would likely use the new flexibility they have been given by the just-enacted budget reconciliation law to scale back benefits and increase the charges imposed on beneficiaries.

"If the federal government shifts large Medicaid costs to the states, some states are likely to turn around and shift a substantial part of those costs to low-income beneficiaries," said Schneider. "And since low-income people have nobody they can shift costs to, they likely will end up paying the price, partly in the form of less health care."

# # #