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

February 18, 2005

MEDICAID BUDGET PROPOSALS WOULD SHIFT COSTS TO STATES AND BE LIKELY TO CAUSE REDUCTIONS IN HEALTH COVERAGE

Administration's Proposal Also Implies Cap on Federal Funding

By Victoria Wachino, Andy Schneider[1] and Leighton Ku

The President's budget for fiscal year 2006 includes major proposals relating to Medicaid, the health care and long-term care program for low-income Americans that is jointly funded by the federal government and the states. The Administration proposes to reduce net federal funding for Medicaid by $45 billion over the next ten years.

These reductions would have significant implications for the program's ability to provide health care coverage to low-income uninsured Americans and for states' ability to finance their share of program costs. Many states are struggling to fund their share of Medicaid costs. A number of states are responding by instituting changes that terminate coverage for groups of low-income beneficiaries (generally causing most such beneficiaries to become uninsured) or deny coverage for certain services that some beneficiaries — in some cases, those who are the sickest and require the most prescriptions or longest hospital stays — may need. Proposals that would shrink the federal government's contribution to state Medicaid costs without reducing Medicaid costs themselves would shift financial burdens to states.

Most states would not be able to absorb the added burdens and be forced to choose between reducing Medicaid coverage or benefits — thereby further increasing the numbers of low-income Americans who are uninsured or underinsured — and raising taxes or cutting funding for other priorities such as education. In the face of the growing Medicaid financing squeeze that states are facing, federal savings in Medicaid should be reinvested in the program to help states avert actions that cause the number of uninsured Americans — now 45 million — to climb still higher.

In addition to the proposed Medicaid funding reductions contained in the Administration's budget, the budget also includes a significant proposal that suggests the Administration may be seeking a major structural change in Medicaid that would further disadvantage beneficiaries and states. The Administration proposes to "modernize" Medicaid and the State Children's Health Insurance Program to give states more "flexibility" both to restructure coverage for some groups of beneficiaries that Medicaid currently covers and to expand coverage to people not presently covered. The budget offers no specifics on this proposal, except to specify that this change must be carried out in a manner that results in no additional federal expenditures. That statement, coupled with the apparent similarity of the budget's description of this proposal to the rhetoric that surrounded previous Administration

[1] Andy Schneider is principal of Medicaid Policy, LLC.

proposals to cap federal contributions to Medicaid and convert part of the program to a block grant, suggest this proposal is likely to include a cap on at least part of federal Medicaid funding.

Such a cap would represent a profound change in the Medicaid program. It would end the entitlement to coverage for beneficiaries who are covered under the parts of the program that would be subject to the cap, with the result that eligible low-income uninsured people could be turned away or put on waiting lists. A cap also would end the guarantee that states would receive federal funding at a specified matching rate for the health care and long-term care costs they incur in covering eligible beneficiaries. A cap would result in the federal government reducing its share of Medicaid costs over time and would shift more of the burden to the states. In response, states would likely cut back on Medicaid coverage, benefits, and payments to providers.

The Administration's proposals are just the beginning of what is likely to be a major debate over the funding and structure of the Medicaid program this year. Congress will soon begin work on its budget plan for 2006. Congress may include significant reductions in Medicaid in its budget plan, which is referred to as the Congressional "budget resolution." But Congress may be unable to pass some of the specific Medicaid proposals in the Administration's budget.

To hit the level of Medicaid savings that may be called for in the budget resolution, Congress could ultimately consider major structural changes to Medicaid, such as capping federal funding for the program so the funding no longer responds fully to increases in health care costs. Under such an approach, the federal government no longer would be committed to shouldering a specific share of the costs that states incur in operating Medicaid. The changes made in Medicaid this year could have major implications for the program's ability to serve low-income people, as well as for states and health care providers.

Administration Proposals Would Substantially Reduce Projected Federal Support for Medicaid

The Administration's budget proposes $45 billion in federal Medicaid funding reductions over the period from fiscal year 2006 through fiscal year 2015. The Administration proposes to reduce federal funding to states for Medicaid by $60 billion over this period. This gross reduction of $60 billion would be offset in part by $15 billion in proposed new Medicaid-related initiatives, for a net reduction of $45 billion over ten years.[2] These reductions would represent a relatively small percentage reduction in total federal funding for Medicaid and SCHIP, but their impact on states' ability to provide health care coverage would be substantial. For example, $45 billion is nearly equivalent to the total amount of federal funding provided for the SCHIP program for its first ten years of existence, and is larger than the total federal share of funding for

[2] This $15 billion excludes $1.4 billion in funding for the Vaccines for Children program, which is funded from the Medicaid budget account but is administered by the Centers for Disease Control and Prevention.

Medicaid in ten mid-sized states.[3] (It should be noted that the Medicaid reductions that the budget contains would grow larger each year over the ten-year period.)

An Examination of the Specific Proposals

Some Administration proposals to cut funding also would generate state savings; others would not. The Administration would reduce federal Medicaid spending by $60 billion over the next ten years in five broad ways. The Administration is proposing to reduce Medicaid federal expenditures by $15 billion by reducing the amount that Medicaid pays pharmacists for prescription drugs to approximate more closely what pharmacists pay wholesalers for the drugs they dispense.[4] The Administration proposes an additional $4.5 billion in savings by "strengthen[ing] existing requirements for questionable asset transfers" by individuals seeking Medicaid coverage for nursing home care. These two proposals would result in reductions in state as well as federal Medicaid costs. (See Table 1.)

The Administration also proposes nearly $23 billion in reductions from proposals to change the program's financing rules. In advancing these proposals, the Administration argues that states have been drawing down federal matching funds inappropriately.[5] To finance their share of Medicaid costs, a number of states rely on transfers of public funds between state governmental entities (e.g., between a state university hospital and the Medicaid program) or between a local government, such as a county, and the state. These transfers are expressly allowed under Medicaid law.

Over time, some states have used these arrangements inappropriately to effectively increase the federal share of Medicaid costs, and in some instances these funds have gone to purposes not related to providing services to Medicaid beneficiaries.[6] The federal government has responded by taking action to curb the inappropriate use of these arrangements, the most prominent of which are now in substantial decline. A paper by the Kaiser Commission on Medicaid and the Uninsured notes: "These federal statutory and regulatory policy changes have served to curb inappropriate federal Medicaid spending while protecting the basic financing structure of the programs.[7]

---

[3] See Cindy Mann, "The President's Proposals for Medicaid and SCHIP: How Would They Affect Children's Health Care Coverage?", Georgetown University Health Policy Institute, February 2005. In inflation-adjusted terms, total SCHIP funding for 1998-2007 equals $47.4 billion.

[4] The proposal would require states to require state Medicaid programs to pay the Average Sales Price, rather than the Average Wholesale Price, to pharmacies, plus a six percent fee for storage, dispensing, and counseling. (See U.S. Office of Management and Budget, "Major Savings and Reforms in the President's 2006 Budget", February 11, 2005.) The Budget also proposes to change the Medicaid drug rebate formula to replace "best price**"** with a flat rebate to allow "private purchasers to negotiate lower drug prices." According to the Administration, this will not affect federal expenditures. See HHS Budget in Brief, p. 70.

[5] Office of Management and Budget, Budget of the United States for Fiscal Year 2006, p. 143

[6] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity," February 2005.

[7] Ibid.

The budget includes four additional proposals to curtail inappropriate use of these financing arrangements. The budget describes these four proposals generally but offers few details on how these changes would be designed. This makes it difficult to identify exactly which financing arrangements would be affected and to evaluate the particular proposals. As the aforementioned Kaiser paper notes: "The challenge is to craft a policy that finds the balance between maintaining states' ability to use IGTs [intergovernmental transfers] as a legitimate source of Medicaid financing but also assuring that IGTs are not used as a vehicle to support inappropriate Medicaid financing."

The Administration also proposes almost $12 billion in savings from limiting the scope of, and reducing the matching rate for, targeted case management. This is a Medicaid service designed to assist individuals in securing needed medical services and related social services. According to the Administration, the limits that it is proposing on targeted case management would prevent states from inappropriately shifting costs to this service.

Finally, the Administration proposes to secure an additional $6 billion in reductions by capping the federal share of the administrative costs that states incur in running Medicaid. Currently, the federal government and the states each pay half of most state Medicaid administrative costs, such as the cost of making eligibility determinations, conducting outreach, and paying claims. The federal government pays 75 percent of a small number of state administrative costs, such as monitoring the quality of nursing homes and prosecuting fraud and abuse. The Administration's budget proposes to replace these matching arrangements with fixed federal "allotments" to each state for administrative costs, essentially creating a block grant for federal funding for these administrative costs. This is one of the proposals that would reduce federal funding for state Medicaid programs without lowering the costs that states incur.

Taken as a whole, the Administration's proposals would impose $34 billion in new costs on states, as Table 1 indicates. While the Administration's pharmacy payment proposal and the proposed restrictions on asset transfers would save states nearly $15 billion over ten years (using the Administration's estimate of the savings that these measures would produce), the remainder of the Administration's proposed Medicaid reductions would shift $40.5 billion in costs to states, and other Medicaid and SCHIP proposals in the budget would cost states an additional $8.5 billion.

The budget also proposes some modest new Medicaid and SCHIP spending. The Administration also proposes $15 billion in new spending on Medicaid and SCHIP. The budget includes $1 billion for a new outreach initiative to enroll more children in Medicaid and SCHIP, plus an additional $10 billion for the federal share of the costs of covering the children whom the budget assumes would newly enroll in Medicaid and to a lesser extent SCHIP as a result of these outreach efforts.

The assumption that significant numbers of additional children would enroll as a result of this proposal is questionable. States already are struggling to pay for the growing number of current Medicaid beneficiaries, and it is far from clear that large numbers of states would choose to seek out and enroll substantial numbers of additional children. Indeed, few states are spending their existing outreach funding, according to data that states have reported to the Department of Health and Human Services. Nearly half of the states have recently instituted changes that make

Table 1
Estimates of FY 2006 Medicaid and SCHIP Budget Proposals on Federal and State Spending

	Estimated Budget Effects, FY 2006-15	
	Federal	**State**
	(in billions of dollars)	
Budget Proposals Lowering Federal and State Expenditures		
Change pharmacy reimbursement policies (AWP)	-$15.1	-$11.4
Restrict transfer of assets eligibility	-4.5	-3.4
Subtotal	*-19.6*	*-14.8*
Budget Proposals That Lower Federal Funding to States But Do Not Reduce Medicaid Costs (1)		
Restrict intergovernmental transfers	-11.9	11.9
Cost-based reimbursement for govt. providers	-3.3	3.3
Reduce 6 percent limit on provider taxes to 3 percent	-6.2	6.2
Restrict managed care provider taxes	-1.4	1.4
Reduce match on targeted case management	-4.0	4.0
Further restrict targeted case management and other	-7.7	7.7
Cap Medicaid administrative expenditures	-6.0	6.0
Subtotal	*-40.5*	*40.5*
New Initiatives and Extensions		
Cover the Kids outreach initiative (2)	11.3	6.9
New Freedom demonstrations (3)	1.8	1.1
Respite for Children demonstration (4)	0.9	0.0
Spousal exemption for working disabled	0.3	0.2
Extend transitional medical assistance (TMA)	0.4	0.3
Extend Medicare premium assistance (QI)	0.2	0.0
Extend refugee exemption	0.1	0.1
Subtotal	*15.0*	*8.5*
TOTAL, FY 2006-2015 (5)	**-$45.1**	**$34.3**

Notes:

1 These policies reduce federal payments to states. States may respond by reducing state Medicaid or other state expenditures to offset the loss of federal funds or increasing state funding for Medicaid to compensate.

2 Both federal and state expenditures for the outreach campaign are uncertain and depend on the extent to which states or other parties participate and the effectiveness of outreach.

3 The budget says that the federal government will fund the full cost of demonstrations in the first year but expects states to support the projects at regular matching rates after that year.

4 The proposal is not clear about requirements for state funding. We assume no state funding.

5 The total may differ slightly from the amount shown in the Administration's budget, due to rounding.

Source and Basis for Calculations:

The estimates of federal savings are based on documents released by HHS on February 11, 2004. The estimates of state savings or costs are based on average state and federal matching rates or on the apparent loss of federal matching funds. The estimates above do not include a proposed $1.4 billion increase in funding for Vaccines for Children, which is independent of Medicaid and administered by the Centers on Disease Control and Prevention, but is included in the Medicaid budget account.

it harder, rather than easier, for otherwise-eligible children and their families to enroll in and maintain Medicaid and SCHIP coverage.[8] The budget also includes about $3 billion for demonstration programs to aid people with disabilities and their families, most of which the Administration has proposed in previous years but Congress has not acted on, and about $1 billion to extend expiring programs like Transitional Medical Assistance.

Some of the Administration's proposals warrant consideration. Several of the proposals in the budget appear to warrant consideration. Prescription drugs are a significant factor behind increases in Medicaid costs and account for a substantial share of Medicaid expenditures. In 2002, the Medicaid program spent nearly $30 billion on prescription drugs; between 1998 and 2002, Medicaid spending on prescription drugs nearly doubled.[9] Federal proposals to give states new tools to reduce the price of these drugs without compromising access to, or the quality of care for, beneficiaries would both reduce federal costs and ease some pressure on state Medicaid budgets. In addition, while there are current policies to ensure that beneficiaries who qualify for nursing home care under Medicaid do not inappropriately transfer assets to their families and heirs, the federal government should take stronger action if these policies are being abused.

Accordingly, these proposals appear attractive in principle. Sufficient detail on these proposals has not yet been provided for the proposals to be assessed fully and for their impact on beneficiaries and providers to be evaluated.

Federal policies that would limit use of inappropriate state financing arrangements also warrant consideration. The General Accounting Office and HHS' Office of the Inspector General have both expressed concern about these arrangements.[10] The federal government has instituted a series of strong reforms in recent years that have significantly curtailed states' ability to draw down federal funds in a questionable manner. As a result of these reforms, federal expenditures associated with one of the most prominent of these financing arrangements — "upper payment limit" expenditures — are projected to decline substantially in the years ahead. The Department of Health and Human Services also has significantly increased its enforcement efforts to curtail inappropriate financing arrangements. If problems persist despite these actions to curtail them, additional reforms should be put in place.

But other proposals are highly problematic. Other Medicaid proposals in the Administration's budget, however, are problematic. The proposed cap on federal funding for state Medicaid administrative costs would be especially deleterious. The federal government's share of Medicaid administrative costs is an essential source of the financing for state efforts to

[8] Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, Kaiser Commission on Medicaid and the Uninsured," October 2004.

[9] Brian Bruen and Arunabh Ghosh, "Medicaid Prescription Drug Spending and Use," Kaiser Commission on Medicaid and the Uninsured, June 2004.

[10] See "Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes," GAO-04-574T (March 18, 2004) Testimony of Kathryn G. Allen of the General Accounting Office before the Subcommittee on Health, House Committee on Energy and Commerce; "Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed," General Accounting Office, GAO-04-228 (February 13, 2004); Office of Inspector General Audit, "Review of Tennessee's Intergovernmental Transfers," (A-04-02-02018), May 25, 2004.

safeguard the quality of nursing home care, prevent Medicaid fraud and abuse, and conduct outreach to eligible but uninsured individuals. This year, state Medicaid programs also will be required to help administer the low-income subsidy for Medicare prescription drug coverage. This is a major new administrative burden being imposed on states by the federal government.

It should be noted that administrative costs constitute a significantly smaller share of overall health care costs in Medicaid than in private health insurance. Moreover, capping federal funding for state administrative costs is very likely to lead states to scale back activities in areas such as assuring nursing home quality, preventing improper billing by providers, upgrading computers and related systems that can strengthen program integrity and ensure the accuracy of eligibility determinations, and conducting outreach to uninsured working-poor families.

Congress is likely to include cuts in Medicaid funding in the budget resolution but not to adopt some of the specific proposals in the budget. As Congress takes up the Administration's proposed budget, there is a strong possibility that both the size of the Medicaid reductions and the specific policies adopted to secure the savings will change significantly from what the Administration has proposed.

The first step in the Congressional budgeting process is for Congress to develop a budget plan, known as a "budget resolution." As Congress writes this budget plan, it could incorporate into the plan the Administration's proposed $45 billion in net Medicaid savings, or it could call for larger or smaller Medicaid reductions. If, as seems likely, Congress approves a budget resolution that calls for some level of reductions in federal Medicaid funding, it will be up to the authorizing committees in the Senate and House — the Senate Finance Committee and the House Energy and Commerce Committee — to develop the specific policies to achieve the required level of savings.

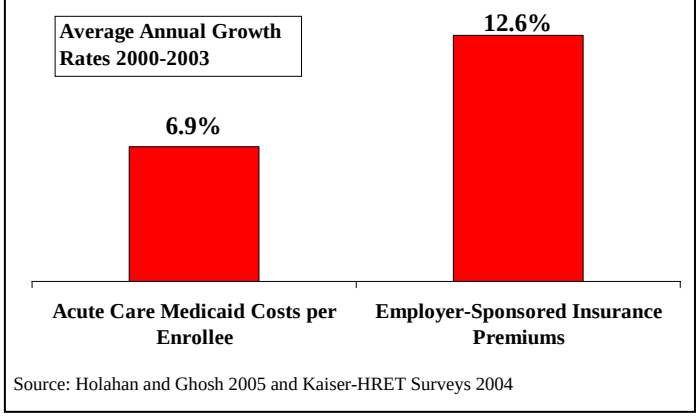
These committees are unlikely simply to accept all of the specific changes the President's budget proposes. Some of the policies that the Administration is proposing are likely to be controversial on Capitol Hill because they would affect significant constituencies such as pharmacists, senior citizens, and the states. Some similar proposals have been made in previous years but not been enacted. If the budget resolution requires substantial Medicaid savings, there is a possibility that the authorizing committees may consider a cap on federal funding for the program as a means to achieve these savings, thereby ending the entitlement to health coverage for eligible low-income families and individuals as well as the assurance to states that the federal government will continue to shoulder its historic share of Medicaid costs.

Many of the Proposed Cuts in Federal Medicaid Funding Would Shift Costs to States, Reducing States' Ability to Fund Health Care Coverage

States face challenging fiscal conditions that are making it increasingly difficult for them to maintain health care coverage for their low-income populations. Medicaid and the much smaller SCHIP program have been quite successful in recent years in mitigating the effects of the erosion in employer-based coverage on low-income families, and especially on low-income children. Without the responsiveness of Medicaid and SCHIP, the increase in the number of uninsured Americans in the past few years would have been much greater.

Many states have been facing trying fiscal circumstances, however, and most states have instituted changes in Medicaid in recent years that have restricted eligibility, narrowed the health care services that Medicaid covers, reduced payments to providers, and/or made it more burdensome to enroll in Medicaid, as part of efforts to balance their budgets.[11] Partly as a result, the increase in Medicaid costs per beneficiary, while significant, has been *much lower* than the rate of increase in health insurance costs in the private sector.

Figure 1.
Medicaid Expenditures Per Person Have Grown More Slowly Than Private Insurance Costs



Source: Holahan and Ghosh 2005 and Kaiser-HRET Surveys 2004

Although general state fiscal conditions are now improving, state revenues are unlikely to reach levels adequate to fund anticipated increases in Medicaid costs, which are being driven in part by increased enrollment as Medicaid responds to the continued erosion of employer-based coverage and in part by continued increases in health care costs driven largely by advances in medical technology and treatments.[12] The increasing cost of long-term care for low-income elderly and disabled people who qualify for both Medicare and Medicaid, but can generally receive coverage for long-term care *only* through Medicaid, is further increasing pressures on state Medicaid costs. Those pressures will only grow as the baby-boom generation retires and the number of older people swells.

The Medicaid funding reductions that the President's budget proposes would exacerbate these pressures on state budgets. Of particular concern are proposals that would reduce federal Medicaid funding without producing any accompanying savings for states. Of the $60 billion in proposed gross federal funding reductions over ten years, only one third — a little under $20 billion — would result from policy changes that produce savings for *both* the federal government and the states. The remaining $40 billion in reductions, which result from the proposals to restrict use of state financing arrangements, cap federal funding for state administrative costs, and limit funding for targeted case management, simply shift costs from the federal government to the states.

To be sure, some of this $40 billion would be the result of savings from proposals to limit inappropriate use of financing arrangements, which may warrant consideration. It needs to be recognized, however, that limiting these arrangements will decrease funds that states have been

[11] Vern Smith, et al., "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005," Kaiser Commission on Medicaid and the Uninsured, October 2004.

[12] Center on Budget and Policy Priorities, "Future Medicaid Spending Growth is Due Not to Flaws in the Program's Design, but to Demographic Trends and General Increases in Health Care Costs," January 2005;and John Holahan and Aranabh Ghosh, "Understanding the Recent Growth In Medicaid Spending 2000-2003," Health Affairs, January 26, 2005.

using to support their Medicaid programs. Closing down these arrangements thus would create significant additional fiscal pressure on a number of state Medicaid programs.[13]

Shifting this $40 billion in federal costs to states would have a negative impact on state Medicaid programs. States are unlikely to be able simply to absorb these costs. Instead, most states would have to choose among a set of difficult options: raising taxes, cutting funding for other priorities such as education, and cutting their Medicaid programs, including both eligibility and the medical services that Medicaid covers. To the extent that states chose to deal with the costs shifted to them by the federal government by cutting Medicaid, as many states likely would do, the number of uninsured and underinsured Americans would be very likely to rise.

Federal Savings Should Be Reinvested in the Medicaid Program to Help States Fund Health Coverage

Proposals that have the potential to increase Medicaid's efficiency *without* reducing coverage, benefits, or access for beneficiaries should be considered. But because Medicaid is already a relatively low-cost program, with per-beneficiary costs that are significantly lower than under private coverage,[14] the number of efficiencies that can meet this criterion is limited.

Moreover, to the degree that reasonable proposals can be identified that would reduce federal costs, the federal savings should be reinvested in measures to strengthen states' ability to finance their share of Medicaid costs and maintain the health-care safety net that Medicaid provides. Such savings could be reinvested to help states cope with enrollment increases that stem from the erosion of employer coverage or to help states finance the increasing costs for long-term care that will come as the population ages. At a minimum, such federal savings should be shared with states. The Medicaid program is a federal-state partnership, and federal savings should not be secured at the expense of states, especially in light of the increasingly serious Medicaid financing problems that states face.

In other words, federal savings should be redirected to help states address the financial problems that are making it difficult for states to maintain health care coverage and to prevent cutbacks in Medicaid eligibility that would enlarge the ranks of the uninsured.

In Addition to $45 Billion in Cuts, the Budget Also Implies a Cap on Federal Medicaid Funding

The Administration is proposing to give states new "flexibility" that states supposedly could use to expand Medicaid coverage for low-income individuals by restructuring the coverage available to current beneficiaries. The budget says that this proposal, which it terms "Medicaid

[13] The impact would not be evenly distributed; — some states would be affected very little; others a great deal.

[14] Jack Hadley and John Holahan, "Medicaid: A Lower Cost Approach to Serving a High Cost Population," Kaiser Commission on Medicaid and the Uninsured, March 2004.

and SCHIP modernization," would build on SCHIP and the Administration's Health Insurance Flexibility and Accountability (HIFA) waiver initiative.[15]

The budget states this policy would be carried out "without creating additional costs to the Federal Government." The budget fails to provide information on whether or how changes in Medicaid's financing structure would be made to ensure that federal costs do not rise as a result of this approach. The flat statement that the federal government would incur no additional costs under this policy, however, implies that the "flexibility" policy the Administration seeks to advance will include a cap on at least part of federal Medicaid funding for states.

In its budget proposals for fiscal years 2004 and 2005, the Administration proposed or endorsed giving states the option of accepting a cap on Medicaid spending in exchange for added flexibility to restructure coverage under Medicaid for so-called "optional" beneficiaries. (Optional beneficiaries are those whom federal law allows but does not require states to cover.) This essentially was a proposal to convert a major part of Medicaid to a block grant. The proposal in the Administration's new budget may be similar to that proposal and could come with a cap on federal funds.

The two models that the Administration describes as forming the basis for its Medicaid "modernization" proposal — SCHIP and waivers under the Administration's Health Insurance Flexibility and Accountability initiative — both include caps on federal funds. SCHIP is a block grant to states to provide health coverage for uninsured low-income children with incomes modestly above Medicaid eligibility levels.[16] Within the cap on federal funding for SCHIP, states receive fixed allotments of federal funds each year. Unlike in Medicaid, children in SCHIP do not have an entitlement to coverage, and a number of states have closed enrollment in their SCHIP programs in response to state budget pressures and concern about the adequacy of federal SCHIP funding to the states. Eligible uninsured low-income children in these states are denied entry to the program. Similarly, HIFA waivers cap federal funds to ensure that the waiver does not increase costs to the federal government.

More broadly, if the federal government provides sweeping additional flexibility in Medicaid, it is likely that such flexibility would be accompanied by a cap on federal funding for part or all of the program. Substantially loosening federal standards on the medical services that must be provided to a beneficiary for a state to be able to claim federal Medicaid matching funds could allow states to shift a portion of the costs of some state-funded services programs onto Medicaid. To prevent the federal government from incurring increased costs, federal policymakers would likely seek to impose a cap on Medicaid funding. [17]

---

[15] Budget, p. 137. See also February 3, 2005 speech by Department of Health and Human Services Secretary Mike Leavitt to the World Health Congress, "Medicaid: A Time to Act."

[16] The Budget also proposes to reauthorize the SCHIP program this year, instead of in 2007 when its authorization expires.

[17] See Cindy Mann, "The President's Proposals for Medicaid and SCHIP: How Would They Affect Children's Health Care Coverage?", Georgetown University Health Policy Institute, February 2005.

Caps on federal funding for Medicaid would represent a far-reaching change in the structure of Medicaid and raise extremely serious concerns.[18] Caps on federal funding for parts of Medicaid, such as the coverage of optional beneficiaries, would end the entitlement to Medicaid coverage for the millions of low-income people covered under the part of the program that would be capped. Moreover, caps would sever the link between increases in health care costs and the provision of federal funding to help states cover those costs. With a cap, federal funding could fail to keep pace with health care costs, and the federal government's share of Medicaid costs consequently could fall appreciably over time (unless states steadily cut their programs). Federal funding caps thus would likely shift growing health care costs and risk to states, including the risk of rising of having to shoulder a considerably larger share of the costs of long-term care for a rapidly aging population.

To handle this shift in costs and risk, many states almost certainly would consider revisiting Medicaid coverage and benefits. The likely result would be increases over time in the number of uninsured and underinsured low-income families and individuals. A cap would have a major impact on states, beneficiaries, and providers alike. If the Administration does, in fact, intend to seek a cap on part or all of federal Medicaid funding as part of its Medicaid modernization proposal, then the proposal for a cap should be spelled out clearly and in full for Congress, the states, and the public to consider.

Conclusion

Federal Medicaid funding reductions of the size that the Administration has proposed and some of the specific proposals it has put forward are likely to be injurious to states' ability to provide health care coverage through Medicaid. Administration proposals that would reduce federal funding without producing any accompanying state savings would shift costs to states that many states would not be able to absorb. As a result, states would likely feel compelled to institute reductions in Medicaid coverage and benefits that would lead to increases in the number of uninsured and underinsured low-income people. To help avert such an outcome, savings from reductions in federal funding that do not produce savings for states should be reinvested in the Medicaid program to help states finance the growing cost of providing health coverage to low-income Americans, especially the rising cost of Medicaid coverage for low-income people who are elderly or suffer from disabilities.

The budget also includes language that implies that some or all of federal Medicaid funding would be subject to a cap or a block grant. Capping federal funding would represent a profound change that would shift costs and risk to states and be likely to erode health coverage significantly over time. If the Administration seeks a cap, it should be forthcoming with its proposal, spelling it out for Congress and the public.

[18] See, for example, Jeanne Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," Milbank Quarterly, January 2005, and Cindy Mann, "Medicaid and Block Grant Financing Compared," Kaiser Commission on Medicaid and the Uninsured, February 2004.