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ADMINISTRATION'S MEDICAID PROPOSAL WOULD SHIFT FISCAL RISKS TO STATES

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The Bush Administration's fiscal year 2004 budget proposal appears to provide a modest amount of funding to help states meet Medicaid costs during this time of state fiscal crisis. This offer, however, comes with a major catch. States that opt for this fiscal relief would receive lower federal Medicaid payments than they otherwise would get, starting in fiscal year 2011. In addition, states would have to accept a significant risk that the capped federal payments they would receive even in the years *before* 2011 would not keep pace with increases in costs they incur and thus would fall short of what they would have received under current law.

- From 2004 to 2010, states would, as a form of short-term fiscal relief, receive capped payments that would exceed by $12.7 billion the federal Medicaid and SCHIP payments they currently are *projected* to receive under current law. Then, in fiscal years 2011-2013, states would be required to repay these additional funds through reductions in the capped federal payments they receive in those years. The President's budget shows that states would receive $150 million less in federal funding in 2011 than they are projected to receive under current law, $4.4 billion less in 2012, and $8.3 billion less in 2013.

- In exchange for this "loan" against future payments, states would have to give up open-ended federal Medicaid financing and transform their Medicaid and State Children's Health Insurance Programs (SCHIP) into a capped, consolidated block grant. Federal payments to states would no longer be tied to the actual costs that states incurred in operating their Medicaid programs.

- If the actual costs that states incurred over the next ten years turned out to be higher than had been anticipated, the capped federal block-grant payments would fall short of actual costs, and states would receive less in federal funding even before 2011 than they would have received under current law. Actual state costs in Medicaid are affected by a number of factors that cannot be predicted accurately in advance, including changes in the economy, changes in the size and demographics of a state's population, developments in medical technology (including the emergence of new and improved but costly treatments), and other difficult-to-

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predict factors that can affect health care costs in both the public and private sectors, such as the outbreak of an epidemic or the onset of new diseases. States opting for the block grant would bear the risk that actual costs would exceed the predictions the federal government used when setting the block-grant allotments. If that occurred, states would either have to pay the additional costs entirely from state funds or to scale back the coverage available to state residents.

Under the proposal, states would receive an annual allotment from the federal government to fund two programs — one for acute care (e.g., physician, pharmacy and hospital services) and one for long-term care (e.g., nursing home and community-based long-term-care services).[2] States could use up to 15 percent of their allotment for program administration and direct payments to safety net providers.

A state's allotments would be based on the amount of federal Medicaid funds (including Disproportionate Share Hospital payments) and certain SCHIP funds the state had received in fiscal year 2002. The amount of the capped payments that would be provided to states would be adjusted upward each year, with the annual adjustments based on a pre-determined formula that would be established in legislation or through negotiated state adjustment rates, rather than on changes in the actual number of people served and the actual cost of services. If program costs exceeded the capped amount, a state opting for the block grant would not receive additional federal funding.

This approach holds risk for states.

- The federal government and the states currently have a financial partnership, under which they share the risks and the burdens of greater-than-anticipated increases in Medicaid enrollment and health care costs, which are notoriously difficult to forecast accurately. The block grant would terminate this partnership. It would cap the federal government's financial commitment and absolve the federal government of any risk or responsibility related to greater-than-expected increases in costs.

- This change would come at a time when health care costs are rising rapidly and the retirement of the baby-boom generation, which will bring with it large increases in health care costs whose magnitude cannot be predicted precisely, is only a few years off.

- No information has been provided on how the annual adjustments in block-grant allocations to states would be determined. If the block-grant funding levels were adjusted each year by the same percentage amount for all states, the impact would be quite varied among the states, since the factors that cause state health-care expenditures to rise over time do not have uniform effects across the states. A one-size-fits-all percentage adjustment would not serve states well.

[2] Initially, the Administration proposed two distinct allotments but this part of the proposal has reportedly been dropped.

- State-specific block-grant adjustment rates would not fully address these problems either. Under such an approach, the total amount of federal block-grant funding for a fiscal year would presumably be fixed. The amount that each state would receive would then be determined either through negotiated adjustment rates (with different rates established for each state) or through a formula that would be used to compute state-specific adjustment rates each year, based on a set of pre-determined factors. If payments to states were based on negotiated adjustment rates, states would essentially compete with each other over how much of the increase (and in later years, the decrease) in federal funding each state would get. States would have difficulty estimating and defending the proper adjustment rate for their state, given the difficulties involved in projecting the percentage amounts by which Medicaid costs will rise each year. The process would likely be somewhat arbitrary and could be subject to political influence, in part because of the lack of objective standards for setting state-based adjustment rates.

- If instead of state negotiated adjustment rates, a formula for distributing funds to states was developed that resulted in the computation of annual payment adjustments for each state based on a pre-determined set of factors, the formula would only be as good as the factors included in it and the data used to make the adjustments. It would be virtually impossible to take into account in such a formula all of the myriad factors that contribute to changes in state Medicaid costs. In addition, the state-based data that would be needed to effectuate such adjustments often are not unavailable, are not reliable (or at a minimum, are subject to varying reliability across states), or are available only after a significant time lag.

- Even if a formula did a tolerable job of anticipating cost increases in a particular state, this would be of limited help if the *overall* adjustment factor used to determine the increase in the total amount of federal block-grant funding available nationally fell short of fully reflecting the increases in costs that states incurred. If that occurred, most or all states electing the block grant could be adversely affected.

- At bottom, setting capped allotments for states entails, by its very nature, making projections in advance of how much health care costs will rise. Over the years, the most sophisticated projections often have fallen well short of costs. For example, the projection the Congressional Budget Office made in 1998 for federal Medicaid spending five years hence (i.e., in 2002) turned out to be 12 percent — or $17 billion — below actual 2002 expenditures.

- Finally, the reduced federal payment levels that states would receive in 2011-2013 could form the basis for reduced payments to states in years *after* 2013, when the block grant would be reauthorized. Given the budgetary difficulties that the federal government is expected to be facing at that time, it is likely that the level of block grant payments that states would receive in 2013 — when the payments would be $8.3 billion below what states are projected to receive under current law — would serve as the starting point for deliberations over federal block-grant funding levels for years after 2013.

For such reasons, New Mexico governor Bill Richardson recently observed, "Capping the federal portion of Medicaid spending leaves states with all the risk."[3]

Once in the block-grant structure, a state would be required to juggle a plethora of needs and demands within a fixed pot of funds. Capped funding essentially creates a "zero sum" game for states.

- Although some question remains about whether certain segments of the Medicaid population (the so-called "mandatory" beneficiaries) would be served with block-grant funds or whether states would continue to receive open-ended federal matching funds for these people, some of the most costly and fastest growing parts of state Medicaid budgets — including most costs for elderly and disabled beneficiaries — clearly *would* come under the capped payment structure. While states would have increased flexibility to change the rules for many beneficiaries and services, it appears unlikely that this flexibility could lead to large savings unless a state took steps to reduce coverage or services significantly.

- In addition, once the economy turns around and states are again in a position to consider making improvements in their Medicaid programs to cover more of the uninsured (and thereby to lower costs for uncompensated care), they would be foreclosed from receiving any additional federal Medicaid payments to help finance such improvements. The federal funds they would receive would be limited to their capped allotments. Any new resources for expansions or other improvements would have to be financed entirely by state funds (or by reducing coverage or services for people whom the state already is covering or cutting provider payments). As a consequence, states would have less ability under the block grant to address unmet health care needs and reduce the ranks of the uninsured than they possess under the current financing arrangements.

In short, while the proposal would increase state flexibility in some areas, it would eliminate what is perhaps the most important element of flexibility for states that is built into Medicaid — the flexible, open-ended federal funding arrangement that lies at the heart of the program and under which states can count on the federal government to bear its share of any unanticipated costs that occur and any eligible expenditures that states determine they need to incur on behalf of their residents. States would no longer be assured of additional federal Medicaid funds in the case of an outbreak of a potentially lethal disease, such as Severe Acute Respiratory Syndrome, or if a new treatment for AIDS or cancer became available or a plant closed and hundreds of families and retirees in a state suddenly qualified for public coverage. The current flexible financing mechanism would be replaced by an inflexible, capped federal funding allocation. That could put states in something of a fiscal straitjacket.

As noted, the block-grant approach would be optional for states. States that declined this offer, however, would be denied any federal fiscal relief during this time of severe budget crisis.

[3] Testimony of Governor Bill Richardson before the House Committee on Energy and Commerce, March 12, 2003.

These and other issues related to the block-grant proposal and its financial implications are discussed in more depth below.

Short-term Federal Funding Increases, Long-term Funding Difficulties

While details of the Administration's Medicaid proposal are still evolving, sufficient information is available from OMB and HHS budget documents and briefings by Secretary Thompson and other HHS officials to assess some of the proposal's fiscal implications for states. It is clear that the proposal poses risks to states.

The fiscal relief in the proposal would be a "loan," rather than a grant. Unlike other, bipartisan fiscal relief proposals that would provide states with increased federal Medicaid matching payments for a temporary period, this proposal would require states to repay all of the funds provided as fiscal relief.

- Repayment would be accomplished through a reduction in the capped block-grant allocations that states otherwise would receive in the eighth, ninth, and tenth years that the block grant would be in effect (i.e., in fiscal years 2011-2013).
- The Administration's fiscal year 2004 budget estimates that under the proposal, $3.25 billion in additional federal Medicaid funds would be provided in fiscal year 2004 to states electing the block grant and a total of $12.7 billion in additional funds would be allocated to these states over the first seven years. All $12.7 billion then would be repaid in the eighth through the tenth years, with federal Medicaid payments in 2013 alone being $8.3 billion below the level that would be provided under current law.
- These figures do not take into account the additional reductions in federal funding for states that would result if states' *actual* costs over the ten-year period exceeded the projections that were used to set the state block-grant allocations, as could well turn out to be the case.

There is a serious question as to whether states could readily absorb $12.7 billion in cuts in 2011 through 2013. These are the years in which the baby-boom generation will begin to retire, and the costs of providing health care for the elderly consequently will swell; the first baby boomers reach age 65 in 2011. (The baby-boom generation consists of people born in the years from 1946 through 1964.) In a press conference in late January, HHS Secretary Tommy Thompson responded to a reporter's question about how states would manage these repayments by observing, "I'm not going to be here to solve that problem."[4]

The reduced federal payments to states from 2011-2013 could be the basis for reduced payments to states after 2013 when the block grant is renewed. It is unclear whether federal payments to states would continue to be ratcheted down in years after 2013;

[4] Transcript, "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan", January 31, 2003, Washington DC, Kaiser Family Foundation, Kaisernetwork.org, page 20.

Administration budget documents are silent on that point. There is reason to fear, however, that the reductions made in federal funding for states in 2011, 2012, and 2013 *would* continue beyond that point.

- Rather than asking states to repay the $12.7 billion in additional funds in even increments in 2011, 2012, and 2013, the budget shows that federal funding would be steadily ratched down (below the amounts that states are projected to receive under current law) by $150 million in 2011, $4.4 billion in 2012, and $8.3 billion in 2013. The substantially reduced payments to states in 2013 would likely serve as the starting point for deliberations over federal block-grant funding levels for years after 2013.

- Moreover, the atmosphere in which Congress would be determining future block-grant funding levels in 2013 could hardly be a more inauspicious one. Under the current long-term budget projections of the Congressional Budget Office, the General Accounting Office, and the Office of Management and Budget, the federal budget is expected, at the time the block grant would be authorized in 2013, to be facing some of its most severe problems in recent memory. All budget projections now show large federal deficits as far as the eye can see, with the deficits growing to potentially dangerous levels as the baby-boom generation retires in increasing numbers (and as various tax cuts reach their fully phased-in levels). Under these circumstances, it would be risky and unrealistic to assume that Congress would increase federal spending for the block grant by reauthorizing the block grant at levels substantially above the reduced 2013 funding level.

- In fact, there would be a substantial possibility that the pattern in 2011, 2012, and 2013 of federal funding declining further each year (relative to current-law funding levels) would be extended beyond 2013 to achieve steadily increasing savings for the embattled federal budget, at states' expense.

States would have to place themselves in something of a fiscal straitjacket to qualify for the "loan." To receive some aid now, states would have to give up the fundamental fiscal protections inherent in Medicaid's financing system. Under current rules, when costs rise for any reason, federal Medicaid matching funds automatically increase to help states cover the new expenditures they are incurring. Under the block grant, that would no longer be the case.

The Administration's proposal indicates that the block-grant allocations which states would receive would be adjusted annually, based on some unspecified formula. This formula could yield a single national adjustment factor each year, with the block-grant allocations for all states being adjusted upward by the same percentage. Alternatively, a formula could be used under which the percentage amounts by which the block-grant allocations were raised from year to year varied among states. While details on how state allocations would be adjusted from year to year have not been disclosed (and may not yet have been developed), it is clear that no formula can fully and accurately capture all of the factors that drive increases in health care costs and in the expenditures that states incur.

- As states know only too well, it is often difficult to project actual Medicaid expenditures *one* year in advance. Many factors influence Medicaid costs. These include changes in the national, state and local economies, trends in employer-based health care coverage, fluctuations in the price of health care services, advances in medical technology, changes in the size and characteristics of a state's population, and changes in poverty rates. To make accurate cost projections based on a national formula applied to all states and to do so as much as ten years in advance, as may be the case here, is simply impossible to do with any degree of accuracy. It is extraordinarily difficult to construct any formula that can do a decent job of predicting how these and other factors will play out and what the effect will be on Medicaid costs.

- Basing block-grant allocations on projections of such factors rather than on the actual costs incurred, as the Administration's proposal would do, virtually guarantees that increases in block-grant allocations will depart from actual increases in costs that states incur by significant amounts.

Indeed, over the years, the most sophisticated projections often have fallen significantly short of actual costs. For example, the Congressional Budget Office's 1998 projection for federal Medicaid spending in 2002 turned out to be *12 percent — or $17 billion — below* the actual level of 2002 expenditures (see Figure 1).[5] Ten-year projections are likely to be considerably farther off the mark.

If it is difficult to project total Medicaid costs *nationally*, it is even more difficult to make accurate projections of costs on a state-by-state basis. As a result, using projections to determine federal payments to states is fraught with risk.

- If national projections are used to establish a single percentage amount by which the allocations for all states participating in the block grant are to be adjusted for a given fiscal year, such adjustments will miss the inevitable variations across states in population growth, the aging of the population, economic growth, poverty rates and health care costs, and other key factors.

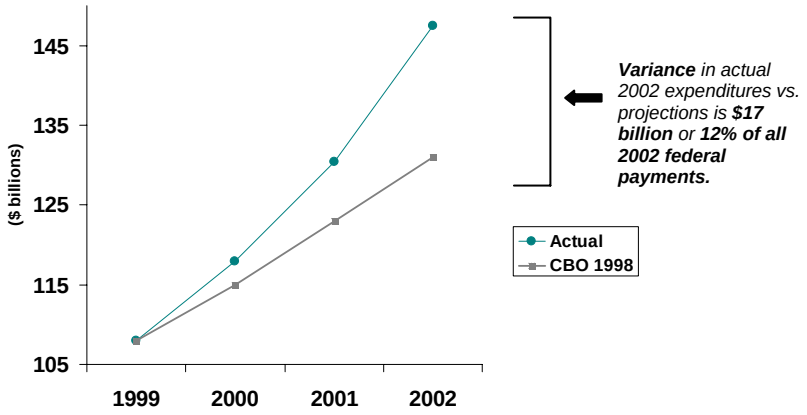
  State-specific adjustment factors could be used instead of a single national adjustment factor, but state-specific adjustment factors pose problems of their own. No formula or set of factors, established before a fiscal year starts, can accurately capture in advance all of the developments that will necessarily influence health care expenditures in a state in the coming year.

[5] While some of the variation between the 1998 estimate and the actual spending for 2002 was due to states' use of Medicaid upper payment limit rules (governing payments to hospitals and nursing homes) and federal legislation enacted after 1998 that led to a growth in federal Medicaid spending, most of the variation was due to changes in the economy leading to increased enrollment, higher participation rates by eligible beneficiaries, an upsurge in health care costs particularly for prescription drug expenditures, and other factors that reflect the kind of unpredictable changes in costs that inevitably arise.

Rather than adopting a national trend rate or state-specific percentage adjustment factors, HHS might seek to negotiate state-specific trend rates with states, as it has done when negotiating some Medicaid waivers with states. States seeking waivers have generally found, however, that negotiating these trend rates for federal Medicaid funding can be a particularly distasteful aspect of the waiver process, since there are no clear standards by which such annual adjustments are to be set and states have little leverage to insist on adjustment rates they believe necessary to cover the increases in costs they will bear.

Figure 1

CBO Federal Medicaid Projections in 1998 vs. Actual Expenditures



Source: Congressional Budget Office historical budget tables, previous editions of its Economic and Budget Outlook.

Moreover, negotiating over annual adjustments in block-grant allocations would likely be even more challenging for states than negotiating funding adjustments in the context of waivers.

- Any state-specific adjustments in block-grant allocations presumably would have to be negotiated against the backdrop of a fixed overall level of federal funding for the fiscal year in question. This would mean that if any state negotiated a better deal, it would do so at the expense of other states.

- This could lead to arbitrary, inequitable and perhaps even politically-driven results.

Regardless of how the annual adjustment factors are determined, a block grant would eliminate what is perhaps *the most important element of flexibility* for states that is built into the Medicaid program. The block-grant approach would terminate the flexible, open-ended federal funding arrangement that lies at the heart of the program, under which states can count on the federal government to "pull its weight" and bear its share of any unanticipated costs that occur and of any eligible costs that states determine they must incur to meet the health-care needs of their residents. This flexible financing mechanism would be replaced by an inflexible, capped federal funding allocation. This would put states in something of a fiscal straightjacket.

- No longer would states be assured of additional federal Medicaid funds if a new treatment for AIDS, schizophrenia or cancer became available or if a plant closed or a firm went out of business and hundreds of families and retirees in a state suddenly qualified for public coverage.

- States would have to manage large and growing costs, including the burgeoning costs of long-term care and other health care services for an aging population, within the confines of fixed, inflexible federal payment caps.

The Administration's proposal could create significant inequities among states. Any plan that sets fixed payments to states based on a pre-set formula raises questions of fairness across states. Inequities could arise in a number of ways. Both national and state-by-state annual adjustment factors could result in there being relative "winners" and "losers" among states ("relative," because all states could be losers to the extent that the capped payments fell short of actual costs).

Another possible source of inequities among states relates to the base-year payments under the block grant. The Administration's plan sets fiscal year 2002 as the base year for setting each state's allotments over the ten-year period.

- Setting payments for the future based on the funding that states received in 2002 would lock in the differences that existed among states in 2002 in Medicaid eligibility criteria, the scope of medical services covered, and payment rates for providers. States that had relatively narrow Medicaid programs and/or relatively low provider reimbursement rates in 2002 could receive substantially fewer funds per low-income insured resident for each of the next ten years (and possibly for years after that) than states that had more expansive programs or paid providers relatively higher rates in 2002.

- States with narrow programs or low provider rates would have even less of a cushion to fall back upon if medical costs continue to rise and block-grant allocations prove insufficient. They also would have a difficult time taking steps to improve their programs in the future, since no additional federal matching or other funds would be available to help finance such improvements.

- Exacerbating this problem is the fact that some states were still expanding their Medicaid programs or improving participation rates in 2002, while other states had begun to institute cuts in their programs due to the economic downturn and rising health care costs. States in which state fiscal crises hit earlier and the state acted to slow Medicaid expenditures in fiscal year 2002 would find themselves at a disadvantage compared to states that did not make significant Medicaid changes to respond to budgetary problems until 2003 or 2004.

Other decisions relating to how the base-year payments would be calculated also would have differential and inequitable impacts upon states.

- For example, it is unclear whether states with Medicaid waivers would be allowed (or required) to convert their current financing agreements under the block grant. If states with broad section 1115 waivers were permitted to retain their waiver financing, they might end up with more favorable financing terms than other states. And under a fixed overall level of federal funding for the block grant, that could operate to the detriment of those other states. Alternatively, states with such

waivers could be required to renegotiate the terms of the waivers if they chose the block grant option.

- It also is unclear whether states that took advantage of upper payment limit (UPL) arrangements would be able to fold those payments into their block-grant base payments. Since federal law changes adopted in 2000 prevent other states from taking advantage of these arrangements, this is another potential source of inequity.

- A final likely source of inequity relates to funding for the State Children's Health Insurance Program. The proposed block grant almost certainly would result in some states — including some states that did *not* elect the block grant — losing significant SCHIP funds in the years ahead and having to institute cuts (or make deeper cuts) in their SCHIP programs as a consequence. (See the box below.)

Block Grant Proposal Would Cause Some States to Lose Substantial SCHIP Funding and Compel Them to Institute Sizeable SCHIP Cuts

The Administration's proposal would consolidate Medicaid and SCHIP funds for states that opt into the block grant. Based on statements by Secretary Thompson and other HHS officials, allocations for the block grant apparently would be based on each state's SCHIP allocations that they would otherwise receive.

This approach could seriously harm many states and children. As various analyses have demonstrated, at the SCHIP allocation levels reflected in current law, a substantial number of states will have to institute sizeable cuts in their SCHIP programs in the years ahead and reduce their SCHIP enrollments by several hundred thousand children nationally. The block-grant structure would exacerbate this problem and make the cuts deeper in many of these states.

Under current law, the states that face significant SCHIP funding shortfalls are scheduled to receive substantial additional SCHIP funds, beyond their basic SCHIP allocations. They are scheduled to receive these additional SCHIP funds in coming years through reallocations of SCHIP funds that have been left unspent by other states. If the states slated to receive the reallocated funds do *not* receive these funds, the cutbacks they will have to make in their SCHIP programs in the years ahead will be even deeper. This is precisely the problem the block grant would cause, because it would undermine the SCHIP reallocation system. Base SCHIP allocations in states electing the block grant would be folded into these states' overall block grant funding levels. As a consequence, *there would be no unspent SCHIP funds to reallocate* from these states to the states that expect and need such funds.

The result would be to reduce substantially, and possibly to eliminate, SCHIP reallocations. If states that opt into the block grant can retain all of their SCHIP allocations regardless of whether they need all of these funds to cover children eligible for SCHIP, there will be few, if any, funds to reallocate to other states that have made aggressive use of their SCHIP funds to cover low-income children and need the reallocated funds to maintain their programs. The result would be that the overall SCHIP funding levels which many states would receive would fall significantly *below* what these states would receive under current law (because of the loss of the reallocated funds) — and far below what these states will need to maintain their programs and avoid having to terminate coverage for large numbers of children.

The common response to these equity questions is that the block-grant proposal is structured as an option to states. States that anticipate they will not fare well under the block grant could decide not to take it. There are three problems with this response.

- Some states may not be able to predict accurately how they would fare under the block grant. They may take the gamble now to help address an immediate fiscal crisis but find later on, when they cannot opt out of the block grant, that the capped payments fall well short of their needs.

- A state that decides *not* to take up the block grant because of the risks it poses would forfeit the opportunity to get any federal fiscal relief.

- The problems the block grant proposal presents with regard to SCHIP funding, described in the box on page 10, would affect all states, not just those that choose the block-grant option. If states with substantial unspent SCHIP funds elected the block grant, fewer funds would be available to reallocate to other states and a number of other states would be harmed. (In addition, SCHIP comes up for reauthorization in 2007. If a number of states no longer have SCHIP programs because their SCHIP funds have been consolidated into a block grant, that could affect how SCHIP fares on Capitol Hill when reauthorization comes.)

Savings made possible by reduced state spending requirements might prove to be illusory. The proposal would allow states to withdraw some portion of state spending as compared to current law, by replacing the current Medicaid matching payment system with a "maintenance of effort" requirement. States meeting the maintenance-of-effort requirement would qualify for their federal block-grant allocations.

According to briefings by the Administration, the minimum amounts that state would have to spend to meet the MOE requirement would be adjusted upward each year at a slower rate than the rate at which Medicaid expenditures have been rising. On paper, this provision would appear to allow states to reduce state funding significantly over time, relative to what the states would contribute under current law.

While this aspect of the proposal may appear attractive at first blush to states facing fiscal pressures, the ability of states actually to reduce state funding under this proposal may be more apparent than real.

- Whether a state could really reduce state funding under the block grant would depend on whether, and to what extent, the state could meet demands for health care services within the state within the sum of the capped federal payments it would receive and the maintenance-of-effort funding it would be required to provide.

- To the degree that the capped federal payments proved inadequate, which could easily occur if the federal payments failed to keep pace with actual increases in health care costs, states could be forced to provide *additional* state funds — beyond what they would contribute under current law — to make up for the loss

Examples of Mandatory and Optional Beneficiaries and Services

Mandatory Beneficiaries	Optional Beneficiaries	Mandatory Services	Optional Services*
Children under age 6 and pregnant women below 133% of poverty Children ages 6-18 below 100% of poverty Parents with incomes below their state's AFDC income limit prior to welfare reform Elderly and persons with disabilities on SSI Foster care children	Children above mandatory income levels Pregnant women above 133% of poverty. Working parents above mandatory levels. Elderly and persons with disabilities above the SSI income limit (74% of poverty). Medically Needy (individuals with catastrophic medical expenses, including those needing nursing home care).	Hospital services Physician services Nursing home care (for those ages 21 and higher) Early Periodic Screening Diagnosis and Treatment (EPSDT) for children Laboratory and x-ray services	Prescription drugs Physical therapy Personal care services Home health care (for those not eligible for nursing home care) Home and community-based services Prosthetics and durable medical equipment Vision and dental services * Optional for populations other than children

of open-ended federal funding. The lure of being able to reduce state funding thus could prove illusory.

Even With Promise of Increased Flexibility, States Could be Forced to Reduce or Eliminate Coverage for Some Vulnerable Populations

In exchange for accepting capped federal payments, states would be granted increased flexibility over Medicaid program rules. Ultimately, each state would have to consider whether the flexibility it would gain would allow it to achieve sufficient savings to offset the loss in federal funds that could result under the block-grant option, and whether such savings could be achieved without compromising the health and well-being of beneficiaries and providers in the state.

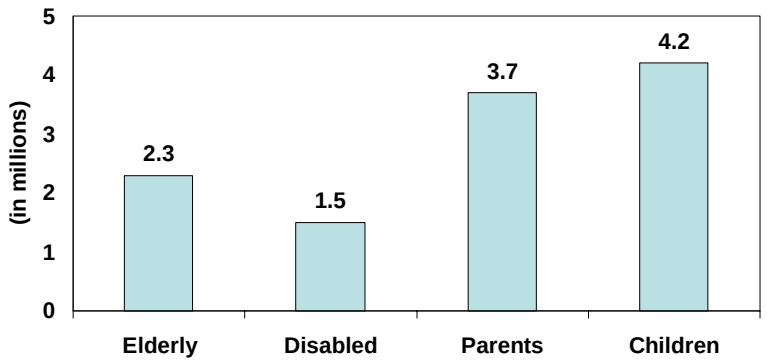
Some of the most costly beneficiaries and services would be under the federal cap. All spending for "optional" groups and "optional" benefits (including optional benefits for "mandatory" beneficiaries) would be financed through the capped federal payments. (See box above.)[6]

[6] Budget documents and Secretary Thompson's statements stress that under the block-grant option, federal standards would continue to apply to those groups of people whom states are required to cover under current law— the so-called "mandatory" beneficiaries. It is not clear whether the financing for mandatory services for the mandatory beneficiaries would be inside or outside of the block grant. Either way, it appears that funding for *optional* services for mandatory beneficiaries — including prescription drugs — would be financed through the block grant. The cost

- In 1998, about one-third of all Medicaid beneficiaries and a majority of elderly beneficiaries — an estimated 11.7 million individuals nationally — were "optional" beneficiaries. They included an estimated 4.2 million children, 3.7 million working parents, 2.3 million elderly individuals, and 1.5 million people with disabilities (see Figure 2).

Figure 2

Number of Medicaid Beneficiaries with Optional Eligibility (1998)



Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

- Furthermore, 65 percent of all Medicaid expenditures in 1998 consisted of expenditures either for optional beneficiaries or for optional services for mandatory beneficiaries. All such "optional expenditures" (and possibly other expenditures as well; see footnote 5) would be financed through the block-grant payments.

These "optional expenditures" would not be easy for states to cut.

- Many optional beneficiaries have very low incomes. In numerous states, parents with incomes as low as 50 percent or 60 percent of the poverty line (or even lower amounts) are optional beneficiaries, as are elderly and disabled individuals with incomes as low as 74 percent of the poverty line.

- Nationally, 85 percent of the nursing-home residents enrolled in Medicaid — a costly group to cover — are optional beneficiaries, and 90 percent of overall Medicaid long-term care expenditures are optional expenditures.

- In addition, *all* expenditures for prescription drugs for beneficiaries other than children are optional expenditures. (Prescription drug coverage is considered an optional service, except for prescription drugs needed by a child, which are covered under a component of Medicaid known as Early Periodic Screening, Diagnosis, and Treatment.)

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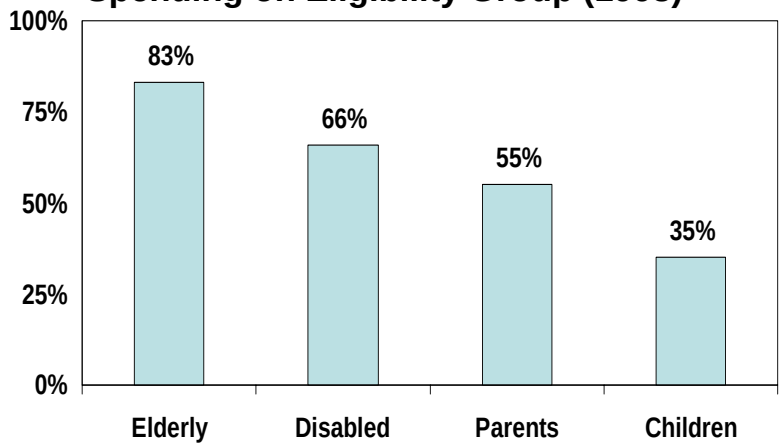
of these services would compete with other needs that also would have to be financed within the capped federal allotments.

- 83 percent of all Medicaid expenditures for elderly beneficiaries and 66 percent of all Medicaid expenditures for disabled beneficiaries are optional expenditures (see Figure 3). Indeed, 83 percent of *all* optional Medicaid spending is for coverage of the elderly and people with disabilities. [7]

Figure 3
Optional Spending as Percent of Total Medicaid Spending on Eligibility Group (1998)



Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

This suggests that if states are not successful in reining in prescription drug costs, nursing-home costs, and/or other costs relating to the elderly and disabled so that these costs fit within the block-grant allocations, states opting for the block grant could find themselves facing serious difficulties. They would either have to bear all of these additional costs themselves without any federal assistance or have to cut expenditures under the block grant for children and families sharply enough to offset the higher costs for the elderly and disabled.

With the retirement of the baby-boom generation approaching, states have been urging the federal government to bear more of the costs of long-term care. The block-grant proposal moves in precisely the opposite direction, capping federal payments for long-term care and, most likely, shifting more of these costs to states over time.

In short, because elderly and disabled beneficiaries account for such a large share of optional costs, states needing to achieve significant savings within their optional expenditure categories would likely have either to institute cuts in the coverage and services provided to elderly, chronically ill or disabled people or to make particularly deep cuts in the much-lower-cost coverage they provide to children and parents in low-income working households.

States will likely react to reduced funding by serving fewer people or providing fewer benefits. It is difficult to see how the new flexibility that states would get would enable them to secure large savings unless this flexibility were used to make major reductions in optional coverage or services. States might achieve some savings through cost containment initiatives and other management efficiencies, but states generally can already take such steps under current law and have strong financial incentives to do so, because of the state matching requirement. Many states have done what they can in these areas. States generally would have to go much farther to

[7] Urban Institute estimates, based on data from fiscal year 1998 HCFA-2082 and HCFA-64 reports (2001).

achieve the added savings they would need under the block-grant structure by the eighth, ninth, and tenth years, if not before then.

The dilemma states would confront is that there is not much "fat" in Medicaid. In 1998, more than 84 percent of acute-care expenditures for Medicaid beneficiaries was for prescription drugs or for services that are required under federal law and that most people would consider basic to insurance coverage, such as hospital care and physician care. All other optional acute-care services — such as rehabilitative care, durable medical equipment, eyeglasses, and dental care — together account for only 16 percent of acute-care spending. What services would states eliminate?

- Enrollment caps or freezes that prevent eligible people from enrolling in the program could yield significant cost reductions, but only by eliminating coverage for otherwise eligible people and leaving them uninsured.
- In addition, if an enrollment freeze were instituted, some costs would continue to be incurred in other ways, such as through public hospital emergency rooms.[8] And after a freeze is lifted, costs could surge, reflecting a pent-up demand for services.[9]

Some states have been seeking increased flexibility in the area of premiums or cost sharing. Whatever the merits of making some changes in Medicaid cost-sharing rules, it is unlikely that states could realize *large* savings from such changes without affecting access to necessary care, given the low incomes of the beneficiaries who could be impacted.

- Many optional beneficiaries have incomes below the poverty line. To achieve large savings by imposing new or increased charges on beneficiaries is likely to entail raising some charges to levels likely to deter enrollment or utilization of necessary services. That could leave significant numbers of people without care they need and shift costs to other publicly funded providers.
- Significantly higher premiums and cost sharing also could result in a more costly group of beneficiaries using services, on average. Those who make the trade-offs in their family budgets necessary to come up with the required payments are likely to be disproportionately those with the greatest health care needs. That, in turn, could cause providers to seek rate increases, which could minimize the savings that states would secure.

States are likely to have difficulty taking advantage of new flexibility to expand or improve coverage. The proposal would accord states the flexibility to cover adults they cannot currently cover under Medicaid without a waiver, such as adults who are not living with children and are not pregnant, disabled or elderly. It would also permit states to improve the delivery of

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[8] J. Hadley and J. Holahan, Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured, *Who Pays and How Much: The Cost of Caring for the Uninsured*, February 2003

[9] P. Silberman, et al, Cecil P. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, for the Kaiser Commission on Medicaid and the Uninsured, *The North Carolina Health Choice Enrollment Freeze of 2001*, January 2003.

long term care services by allowing them greater freedom to provide such services in home and community based settings rather than in nursing homes. Here, too, however, the apparent flexibility may prove illusory.

- Because federal payments would be capped, states would receive *no* new federal funds to help them extend coverage to groups of uninsured people, a sharp departure from current practice.
- Any new coverage or improvements in the coverage provided would have to be financed entirely with state funds or through reductions in health care expenditures for people who currently are covered under Medicaid or SCHIP. As noted, it is likely to prove difficult to extract large savings in these areas.

Conclusion

While many details of the Administration's plan are not yet known, the proposal would, by its very nature, end the longstanding federal-state partnership under which the federal government shares with states the risks of rising health care costs. It would cap the federal government's fiscal liability and thereby make states more vulnerable to growing health costs at the very time the baby-boom generation is approaching old age. This is not an appropriate prescription for what ails states and their Medicaid programs. If Medicaid is to remain a viable and stable source of insurance for those whom the private market will not cover, the federal government needs to remain a full funding partner.

Today, states face their worst budget shortfalls since World War II. Many states currently find themselves driven to make cuts in their Medicaid programs. States' legitimate need for fiscal relief ought to be met by measures that can help them contain costs in effective and responsible ways while assuring that adequate resources are available to help them maintain health care coverage for their residents.

State problems will worsen if the federal government ceases to be a full partner in funding for acute-care and long-term care services. The block-grant proposal takes states in the opposite direction from what many of them have been seeking. Many states have been calling for the federal government to assume a greater share of the cost for long-term care services. Instead, this proposal would cap federal funding for long-term care. By capping and ultimately reducing federal contributions to states in the years in which the baby-boom generation will begin to retire, the proposal diminishes rather than enhances the federal role in helping to shoulder the burgeoning costs that states will face as their populations age and their numbers of low-income elderly and disabled residents grow.

Immediate fiscal relief is surely needed to help states address rising Medicaid costs amidst the current fiscal crisis. More flexibility in certain areas also may be useful in order to provide states with some new tools to manage costs. But neither short-term fiscal relief nor enhanced state flexibility should come at the price of losing open-ended federal financing and shifting all fiscal risk to the states, or of requiring cuts in federal funding for states starting in 2011.

Several bills introduced in the Senate and the House of Representatives with strong bipartisan support would provide states with temporary fiscal relief without these harmful "strings." None of those proposals require repayments or force states to accept damaging changes in the financing structure of their Medicaid programs.

Furthermore, on March 21, the Senate voted 80-19 in favor of a "Sense of the Senate" resolution declaring that the "economic growth" package that Congress is scheduled to pass this spring should include at least $30 billion in immediate fiscal relief to states, with half of that amount being provided to states through a temporary increase in the federal Medicaid matching rate. This resolution does *not* include repayment or block-grant conditions. A combination of short-term fiscal relief of this nature and longer-term financing changes under which the federal government assumes a larger share of the health care costs of low-income elderly and disabled people receiving both Medicaid and Medicare — which could be achieved in part through Medicare prescription drug legislation — would represent a sounder and safer approach for states and beneficiaries than the proposed block grant.

The more closely the Administration's proposal is examined, the more troublesome it appears. It would provide states with a modest upfront loan and some additional programmatic flexibility. But it would require states to pay the money back subsequently and to assume all of the risk if health care expenditures rise faster than the federal government has projected. It also would foreclose states from receiving any additional federal funds to help them extend coverage to more of their uninsured residents.