cc: Chris Jennings

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Health Division

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Executive Office of the President
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Subject: HHS' Loss of Coverage Estimates Under the Conference Agreement

From: HFB Staff NHS

This memo addresses HHS' loss of coverage estimates and offers alternative facts that could be useful for the SOTUS.

HHS Estimates

You requested that we review HHS' recent study that estimated the effect of the Conference Agreement on Medicaid coverage. HHS estimated the loss of coverage in 2002 for current Medicaid beneficiaries under the latest GOP Offer ($117 billion in savings over seven years) and under a block grant which would cut Federal spending by $85 billion over seven years (i.e. Coalition savings).

Because the latest GOP Offer ($117 billion over years) produces the same savings in 2002 as the Conference Agreement, we recommend using coverage loss estimates for the Conference Agreement, which were cleared in December and have previously been used in testimony and talking points. Although HHS has produced more current estimates, due to our reservations

concerning their new methodology (outlined below) and to ensure consistency with previous estimates, we recommend using the following numbers based on the Conference Agreement.

7.7 million people would lose coverage in 2002, including:

- .85 million elderly,
- 1.3 million disabled,
- 3.8 million children.

We would not recommend clearance of the loss of coverage estimates under a block grant which would cut Federal spending by **$85 billion** because: (1) state specific spending estimates in 2002 under an $85 billion package are unknown, and (2) we have reservations concerning HHS' new methodology.

The vetoed Reconciliation bill had a distributional formula from which GAO produced state specific spending estimates -- from which coverage loss in 2002 was calculated. The latest GOP Offer of $117 billion included an additional $16 billion in savings which was distributed in the early years and did not affect spending (and therefore coverage estimates) in 2002. The HHS document did not specify a distributional formula for state specific estimates for the $85 billion offer. HHS assumed that the difference between the $117 and $85 billion packages would be allocated proportionally across states in order to establish coverage loss. This assumption is doubtful, given the uneven distribution of block grant funding in the previous formulas.

Secondly, changes HHS made in UI's assumptions could affect the loss of coverage estimates in both the $85 and $117 billion package, although we are unsure of their distributional impact.

- HHS assumed that recipients lose coverage in proportion to their share of state spending in each state (based on expenditures). Urban, however, assumes that beneficiary reductions are distributed equally across beneficiary groups (based on recipients).

- HHS assumed that states would reduce DSH payments by 25%. HHS did not, however, specify how the reductions would be phased-in. We believe that Urban did not assume that states will reduce DSH spending.

Alternative Facts

The above loss of coverage estimates focus on potential loss of coverage for Medicaid beneficiaries under a Republican block grant proposal. Recent studies have also addressed the *actual* loss of private health care insurance in the U.S. and the expansion of Medicaid coverage -- which could be useful to discuss the importance of Medicaid in assuring health care coverage for low-income Americans.

A study in Health Affairs (Holahan, Winterbottom, and Rajan) found significant declines in employer-sponsored health insurance coverage which coincided with equally significant increases in Medicaid coverage. Thus, the increase in the proportion of nonelderly individuals without

health insurance was relatively small; however, the composition of the uninsured had changed. Overall and among various subpopulations, the study showed that:

Among the nonelderly population:

- Employer sponsored health coverage fell 5.9 percentage points from 67.0% to 61.1% between 1985 and 1993.
- Medicaid coverage increased by 3.9 percentage points from 8.5% to 12.4% during the same period.
- The proportion of uninsured grew by 1.8 percentage points from 15.0% to 16.8% during the same period.

Among families with income less than 100% of poverty:

- Employer sponsored health coverage fell 1.6 percentage points from 13.4% to 11.8% between 1985 and 1993.
- Medicaid coverage increased by 7.6 percentage points from 47.6% to 55.2% during the same period.
- The proportion of uninsured fell by 4.0 percentage points from 30.0% to 26.0% during the same period.

Among pregnant women:

- Employer sponsored health coverage fell 3.5 percentage points from 60.8% to 57.3% between 1985 and 1993.
- Medicaid coverage increased by 5.6 percentage points from 23.4% to 29.0% during the same period.
- The proportion of uninsured fell by 2.8 percentage points from 10.8% to 7.9% during the same period.

Among children under age 10:

- Employer sponsored health coverage fell 7.6 percentage points from 65.2% to 57.6% between 1985 and 1993.
- Medicaid coverage increased by 9.4 percentage points from 18.4% to 27.8% during the same period.
- The proportion of uninsured fell by 1.3 percentage points from 12.0% to 10.7% during the same period.

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THE EFFECT OF THE CONFERENCE AGREEMENT ON MEDICAID COVERAGE

I. SUMMARY:

- **Medicaid Proposals**. Medicaid has become a central focus in the debate over balancing the Federal budget. There are two proposals under consideration:

  - The ***President's Proposal*** has three components: (1) a per capita cap, which constrains the rate of growth in spending per beneficiary; (2) a Disproportionate Share Hospital (DSH) payment reduction; and (3) increased flexibility for states in the management of their Medicaid programs. Its saves an estimated $52 billion over seven years, and limits overall spending growth per beneficiary to about 5%.

  - The ***Conference Agreement*** repeals Medicaid and replaces it with a block grant program with significantly reduced funding. The savings from this cap on Federal spending range from $117 billion over seven years (December 15) to $85 billion (January 8). This cap results in spending growth per beneficiary of about 2% over the period -- down from 7% in the Congressional Budget Office (CBO) baseline.

- **Structure of the Proposals and Coverage.** Medicaid currently covers about 35 million Americans -- 44 million by 2002.

  - ***President's Proposal:*** By preserving the entitlement and allowing Federal funds to increase when enrollment increases, the President's proposal maintains Medicaid as a leading source of health coverage in the United States.

  - ***Conference Agreement:*** The structure proposed in the Conference Agreement does not offer these protections since it: (1) fixes Federal funding to states so that payments do not increase with enrollment; (2) reduces program funding at both at the Federal and state level; and (3) ends the entitlement.

- **At $117 billion in savings, up to 8.6 million could lose coverage.** Under a block grant, states would probably attempt to reduce program costs through provider payment and service reductions before reducing coverage. If states were able to hold cost growth per beneficiary to inflation (2.7 percent) or a rate closer to medical inflation (4.6 percent), they could still have to deny coverage for 5.0 to 8.6 million people by 2002 under the Conference Agreement. This includes:

  - From 300,000 to 550,000 low-income seniors;
  - From 900,000 to 1.5 million people with disabilities; and
  - From 2.6 to 4.5 million children.

- **Even at $85 billion in savings, up to 6.4 million could lose coverage.** Even if the Conference Agreement lowered the targeted Federal savings of $117 billion to $85 billion, coverage is at risk. Assuming the same state allocation formula as in the Conference Agreement, states could be forced to deny coverage for 3.3 to 6.4 million Medicaid beneficiaries in 2002.

- **States at Risk.** One of the key differences between the Conference Agreement and the President's proposal is the Federal commitment to share in unanticipated state costs. In an economic downturn, working people may turn to Medicaid at the same time that the states are strapped for revenue.

    - States could face an additional $8 billion in costs over seven years if enrollment for low-income families were 0.5 percentage points higher than the CBO predicts due to a recession or some other unexpected event.

    - The approximately 8.6 million who could lose coverage at $117 billion in savings could increase by half a million to 9.1 million in 2002 if the enrollment projections are slightly higher than expected. This includes an additional 300,000 children.

- **Consequences of Coverage Loss.** There are three possible consequences of coverage loss:

    - **Financial Hardship and Access Problems.** Given the high costs of health care, people denied coverage under the Conference Agreement may become uninsured. The families of nursing home residents could face costs that average $38,000 per year. Financial barriers may lead to delays in seeking treatment and difficulty in finding providers willing to offer care.

    - **Cost Shift to State and Local Governments.** While the Federal funding for Medicaid would be constrained in the Conference Agreement, the state and local governments would be faced with real needs, real costs, and insufficient Federal assistance.

    - **Cost Shift to the Private Sector.** Providers and ultimately people with private insurance may feel the effect of reductions in Medicaid spending and coverage. If the number of uninsured increases as a result of the proposal, then uncompensated care for providers may increase, along with cost shifting to the private sector.

- **The President Proposal Maintains Coverage.** Proposals such as the President's and those offered by several groups of Congressional Democrats maintain guaranteed coverage and shared Federal financial commitment to states -- protecting coverage.

II. BACKGROUND:

Currently, Medicaid is the primary insurer for low-income families, nursing home residents, seniors and people with disabilities. It is the second largest single health insurance program; in 1999, its enrollment is projected to surpass Medicare enrollment, making it the largest health program in the nation. Medicaid is designed as a partnership between the Federal and state governments to provide basic health care services to low-income families, people with disabilities and seniors. It covered about 35 million Americans, including 18 million children, 8 million adults, 6 million people with disabilities, and 4 million low-income seniors in 1995 (CBO, December 1995). It covers one in four children, and contributes to the cost of care for over two-thirds of nursing home residents.

In the past five years, Medicaid has taken on increased importance as employer-sponsored insurance for low-income workers has declined. Between 1988 and 1994, the percentage of the nonelderly population covered by Medicaid grew from 9 percent to 13 percent, while the percentage covered by private health insurance fell from 67 percent to about 61 percent (Holahan, Winterbottom & Rajan, 1995). These trends are expected to continue. The Congressional Budget Office (CBO) predicts in its December 1995 baseline that enrollment growth will average about 3 percent between 1996 and 2002. Enrollment growth is predicted to be especially high for low-income seniors (3.8 percent) and people with disabilities (4.8 percent) (CBO, December 1995). These enrollment trends reflect the aging of the population, the increase in diseases like AIDS (Wade, Adams and Berg, 1994), and the shift in jobs from the manufacturing sector, which often provides health benefits, to the service sector, which does not (Thorpe et al., 1995).

The future of Medicaid has been called into question in the debate over balancing the Federal budget. While many of the changes in the Conference Agreement are simply reductions in spending, the Medicaid proposal is an overhaul of the current system. Title XIX is repealed and replaced by a "Medigrant" program. The new program, among other things, repeals two major components of the current Medicaid program: the entitlement and shared Federal payments. An entitlement means that certain individuals have a Federally enforceable right to a set of health care benefits. Without the entitlement, each state could have different definitions of who is eligible for what benefits.

It also changes the Federal funding structure from one that pays a percentage of the total health costs incurred by states to one that fixes the maximum Federal funding. The proposal is a "match to a cap", meaning that states and the Federal government split program costs using a matching rate until the Federal payments hit the maximum state "allotment" or cap. Before hitting their caps, the states contribute to the program using a new matching rate whose average state contribution is 37 percent of total costs rather than the current average of 43 percent. After hitting the cap, the Federal contribution does not increase, meaning that the states pay for 100 percent of any additional costs. With Federal savings of $117 billion, the maximum Federal payments are reduced by 13 percent between 1996 and 2002, and the state payments are reduced by about 30 percent, assuming that states contribute to the point where they get their full Federal

allotment using the new matching formula (see Appendices A, B and C).

The end of the entitlement, the limit on the Federal spending, and the reduction in total spending could reduce Medicaid's ability to cover people. There are two safeguards in the Republican proposal to mitigate against outcome. First, states are required to cover low-income children under age 13 and people with disabilities. However, the only mandatory benefits are immunizations and limited family planning -- meaning that a state may call a child "covered" by simply providing a vaccination. The second safeguard is the requirement that states reserve or "set aside" certain percentages of their block grant spending for specified purposes. Most of these set asides are percentages based on 85 percent of the average mandatory expenditures for mandatory eligibles in 1993 and 1994. These set-asides, however, dedicate less than half of all the block grant spending according to a Department of Health and Human Services analysis. Thus, neither safeguard offer strong protections against significant reductions in coverage (Mann, 1995).

Many, including the Kaiser Commission on the Future of Medicaid, the American Medical Association, the Children's Defense Fund, the American Association of Retired Persons, and the former director of the Congressional Budget Office Robert Reischauer, have stated that Medicaid coverage cannot be maintained under the Republican proposal. Several analyses support these statements. The Urban Institute estimated that from 3.8 to 8.8 million people could lose Medicaid coverage in 2002 under a block grant that reduces Federal spending by $183 billion over CBO's February 1995 baseline (Holahan & Liska, July 1995). The Department of Health and Human Services used these results to examine coverage loss for subsequent versions of the block grant formula. In a more recent report on the Conference Agreement (savings at an estimated $163 billion), the Urban Institute examined the trade-off between slowing growth and expanding coverage. Since Medicaid spending is equal to the number of people covered times their average costs, a higher rate of growth in spending per beneficiary means that fewer people are covered. The Urban Institute estimated that states would have to constrain spending growth per beneficiary to 1.3 percent per year to continue coverage as projected by CBO (Holahan & Liska, December 1995).

A study by the American Association of Retired Persons and Lewin-VHI examined the effects of a block grant on long-term care coverage in states. They found that as many as 1.7 million Medicaid beneficiaries in need of long-term care services could lose that coverage in 2000 under a block grant that constrains Federal spending to 5 percent per year (Kassner, 1995). And, the Council on the Economic Impact of Health Reform writes, "regardless of how states choose to exercise their newfound flexibility, it appears unlikely that states will be able to live within the proposed budget figures without constraining services and eligibility" (Thorpe et al., 1995; p. 11). The authors estimate that the Republican Medicaid policy by itself -- without assuming that employer-sponsored insurance will continue to decline -- will increase the number of uninsured by 5 million by the year 2002. This could increase uncompensated care by $4 billion in 2002 (Thorpe et al., 1995).

This study expands on this research by: (1) estimating the effect on coverage of the Conference Agreement block grant, using the December CBO baseline and the reduced state spending under the new matching formula; (2) estimating the effects of lower levels of savings on coverage; and (3) examining what would happen to coverage if enrollment is higher than expected.

III. METHODOLOGY:

A. How Coverage Loss is Estimated

This analysis uses a methodology developed by the Urban Institute for estimating reductions in coverage under a block grant that ends the Medicaid entitlement. In its July 1995 report entitled, "The Impact of the Budget Resolution Conference Agreement on Medicaid Expenditures," Urban Institute analysts produced a range of estimates of the number of people who could lose Medicaid coverage under a block grant in 2002. They did this in three steps. First, they estimated the reduction in Medicaid funding under the block grant for each state in 2002. The reduction in spending under the proposal is the difference between the total baseline and the Federal and state spending under the block grant. For this analysis, the Federal spending under the block grant comes from General Accounting Office's November 12 estimates of the Conference Agreement allotments.[1] State spending under the block grant is assumed to be the amount that the state would need to draw down the full block grant, using the new matching rate. The spending under the baseline comes from DHHS-adjusted Urban Institute state Medicaid baseline, controlled to the CBO December 1995 baseline (Appendix E).

Second, the Urban Institute analysts estimated how much of the Conference Agreement reduction could be offset through efficiencies rather than reductions in coverage. States could reduce provider payment rates and expand managed care, for example, to increase efficiency. Savings from efficiencies were estimated by assuming that states could slow the rate of Medicaid cost growth per beneficiary to specific rates. These rates, according to the Urban Institute analysts, are: (1) an upper bound of inflation plus 1.9 percent (about 4.6 percent on average); and (2) a lower bound of inflation (about 2.7 percent on average).[2] In addition to the savings achieved through slowing Medicaid spending growth, DHHS analysts assumed that states would reduce their Disproportionate Share Hospital (DSH) payments by 25 percent, which is consistent with the percentage reduction in Federal Medicaid spending under the Republican proposal in 2002.

The third step in estimating coverage loss is determining whether the savings from restraining spending growth per beneficiary is enough to offset the reduction in spending under the block

1. The formula released in November was estimated by CBO to save $133 billion over seven years on the CBO December baseline. The additional $16 billion in spending added in the December 15 offer was targeted to years prior to 2002, and thus does not affect this analysis which is based on 2002 data.

2. The Urban Institute report used CBO's projected gross domestic product deflator as their inflation measure; the same measure was used in this analysis.

grant proposal. If the savings achieved through efficiencies are equal to or greater than the block grant savings, then there is no need to reduce coverage from baseline levels. However, if the block grant reduction is greater than the efficiency savings, then enrollment must be limited for states to manage the reduction. This reduction in enrollment is estimated in two steps. First, the remaining loss -- the total block grant reduction minus the savings from cost control-- is allocated to families, seniors and people with disabilities in proportion to their spending. Second, the amount allocated to each group is by dividing the scaled-back spending per beneficiary to yield estimates of the number of people who could lose coverage.[3]

There are several limitations to this study. First, it makes assumptions about state behavior, which has historically been unpredictable. States have different programs, abilities to achieve savings without reducing coverage, and levels of commitments to funding Medicaid. Thus, the results of this study are intended to be illustrative and not necessarily predictive of what will happen in each state. Second, the results are keyed off of baseline projections. The projections of how much will be spent and how many people will be covered by Medicaid are controlled to CBO's December baseline. If CBO's forecast is too high, then these estimates may be overstated. Likewise, if CBO's forecast is too low, then these estimates understate the results.

B. Coverage loss at different levels of savings

The Conference Agreement proposes to reduce Medicaid spending by $117 billion over seven years, $45 billion in 2002. This leads to a question: would there still be coverage loss with lower levels of savings? To address this question, it was assumed that the seven-year savings were scaled back to $85 billion, the savings target in the January 8 offer. This was done by increasing all states' allotments by a 6 percent in each year from 1998 to 2002 to hit the new savings targets.

C. Effects of an economic downturn or other events that increases costs and enrollment

The effects of the Conference Agreement are examined relative to the CBO baseline. Like any forecast, the CBO Medicaid baseline may not precisely predict Medicaid spending in the future. A recession, demographic change, or any number of events could cause future enrollment and costs to differ from CBO's projections. To assess what might happen if enrollment and expenditures are different than projected, CBO's baseline's projected growth rates for enrollment were changed. The rates of growth for low-income adults and children were increased by 0.5 percentage points in each year between 1997 and 2002. The resulting change in coverage and costs were then examined using the methodology outlined earlier.

[3] The Qualified Medicare Beneficiary and Selected Low-Income Beneficiary program spending and recipients were excluded from the analysis because their growth is determined more by Federal Medicare rather than state Medicaid policy.

IV. RESULTS:

A. Coverage Loss under the Conference Agreement:

According to estimates from the December 1995 CBO baseline, the Republican Conference Agreement's Medicaid proposal will produce $117 billion in Federal savings between 1996 and 2002 (Chart 2). It does this primarily by lowering Federal Medicaid spending growth to rates near or below inflation by 1999 (Chart 3). In order to maintain CBO's projected enrollment, Federal Medicaid spending per beneficiary would have to increase at an average rate of 2 percent, with a literal decline in spending per beneficiary by 2002. These growth rates per beneficiary are well below private insurance spending growth, health inflation and general inflation.

Even if states were able to achieve significant savings through provider payment and service reductions, they could be forced to deny coverage to between 5.0 and 8.6 million people in 2002 (Chart 4). This includes: from 300,000 to 550,000 low-income seniors; from 900,000 to 1.5 million people with disabilities; and from 2.6 to 4.5 million children. The upper-bound estimate of 8.6 million losing coverage assumes that states can successfully constrain spending per capita to 4.6 percent on average and reduce DSH payments by 25 percent. This growth rate is significantly below current spending growth per beneficiary (about 7 percent), private sector growth (about 7 percent), and medical inflation (5.3 percent). The lower-bound estimate of 5.0 million assumes that states can, in each year between 1996 and 2002, restrain their spending growth per beneficiary to inflation or 2.7 percent. Maintaining such low spending growth annually is practically unprecedented, and may be impossible given health care inflation and the nature of the populations covered by Medicaid.

The coverage loss varies by state due to two reasons. First, some states can get more savings from efficiencies than others. The more a state can reduce program costs through efficiencies, the less it will have to reduce program costs through limiting enrollment. For example, if a state has a baseline spending growth of 8 percent per beneficiary, then there are more savings from provider payment rate and service reductions available than for the state whose baseline growth rate is 5 percent per beneficiary.

The second reason for the different coverage loss by state is the different treatment of states under the Conference Agreement. In 2002, the Federal funding reduction ranges from a 3 to 50 percent decrease (Appendix A, Chart 7). States with smaller cuts are more likely to be able to manage those cuts without limiting coverage. Additionally, the change in the matching rates also differs by state and has a strong influence on states' ability to cover Medicaid beneficiaries. Some states have significant increases in the percent of total costs paid for by the Federal government -- meaning significant decreases in the amount of state spending. The combination of the lower Federal payments and even lower state payments increases the total reduction, which is the basis of the coverage loss estimates (Appendix B).

B. States could be forced to reduce coverage even at lower savings levels.

Even at a savings level of $85 billion over seven years, a Medicaid block grant could cause coverage loss. From 3.3 to 6.4 million people could lose Medicaid coverage in up to 39 states in 2002 under the Conference Agreement if its formula were applied to spending that produces $85 billion in savings (Chart 5).

Coverage loss could occur at these lower levels of savings for two reasons. First, an $85 billion reduction in Medicaid is not small. The Medicaid program's rate of growth in spending per beneficiary is already at the private sector rate. This reflects the success of states that have been particularly aggressive in reducing costs. Some states have already implemented widespread managed care, nursing home rate reform, and other efficiencies which will make it harder to find additional savings to managed within a fixed block grant.

Second, the block grant formula proposed by the Conference Agreement does not take into account states' projected Medicaid enrollment. The Republican formula produces large reductions in some states whose cost growth is primarily due to enrollment or case mix increases. When the spending growth rates per beneficiary under baseline and the Conference Agreement are compared, it becomes clear that some states such as Minnesota, Massachusetts, New York, Rhode Island and Washington are disproportionately affected by the formula (Chart 6).

C. Economic downturns and other unexpected events could increase coverage loss.

One of the defining characteristics of a block grant is its certainty: maximum Federal funding for Medicaid is set in law and will not change. The amount from that fixed pool that a state receives is based on a formula that incorporates states' number of people in poverty and costs relative to national averages. However, analyses by both the General Accounting Office (December 1995) and the Urban Institute (December 1995) indicate that only a very small number of states have funding that changes over time in response to changing need -- almost all states have their funding determined by maximum and minimum growth rates. Thus, the amount that most states receive under the Republican proposal is set now for the next seven years.

While Federal funding is virtually fixed under the proposal, Medicaid costs have historically varied widely, and may also be unpredictable in the future (Chart 3). The General Accounting Office, in a simple study, found that Medicaid enrollment and costs are linked to the changes in unemployment and cycles in economy (GAO, April 1995). A more in-depth analysis found that the major causes of increases in enrollment and expenditures include changes in state and Federal policy, state economic conditions, and the prevalence of diseases like AIDS (Wade, Adams & Berg, 1994). Few of these factors are predictable.

Program costs in the future may also differ from what is predicted. The Congress has made as a term of the budget negotiations the use of the Congressional Budget Offices's baseline assumptions. These assumptions, while different than those of the Administration's, seem reasonable to most Medicaid analysts. However, there are many reasons why CBO's projected Medicaid baseline may not reflect what will happen in the future. An increase in the incidence of

AIDS or Alzheimer's disease, the increasing number of elderly and people over the age of 85, or an unanticipated economic downturn could all significantly alter the yearly estimates of the number of people covered by Medicaid between now and 2002. Acknowledging the limitations of forecasting and estimating program costs in future years, CBO has produced both analyses of the performance of their forecasting (CBO, January 1995) and "rules of thumb" or estimates of what program costs might be if key variables are higher or lower than predicted. The Center on Budget and Policy Priorities used CBO's rules of thumb about Medicaid costs and unemployment rates (Mann & Kogan, 1995). They estimated that a mild recession could increase total enrollment-related Medicaid costs by $7 billion, and a deep recession could cause costs to increase by $26 billion between 1996 to 2002. All of this unexpected increase in costs would be borne by the states under the Conference Agreement.

To assess what would happen to state costs and coverage if enrollment were slightly higher than projected -- either due to an economic downturn or an underestimate of projected enrollment -- it was assumed that the enrollment growth rates for adults and children were 0.5% higher in each year between 1996 and 2002 than under the CBO baseline.

If low-income families' enrollment were slightly higher than expected, states would have to pay an additional $7.6 billion in costs over seven years to cover these people. In fact, if program costs arise for any reasons, including inflation, the states would be liable for the unexpected increase (Appendix C).

Since Federal funding is fixed, however, unexpectedly high costs means fewer eligible people can be covered. While up to 8.6 million could lose coverage under the Conference Agreement using CBO baseline assumptions, 9.1 million could lose coverage in 2002 if baseline enrollment were slightly higher. This includes an additional 300,000 eligible children who could be denied coverage on top of the 4.5 million children that the states may not be able to afford to cover in 2002 at seven-year savings of $117 billion. Coverage loss due to a recession is likely because states have few other tools to control rapidly rising costs on a short-term basis -- recessions can't be planned for with policy changes intended to control cost growth.

V. CONCLUSIONS

This study examined the effects of the Conference Agreement on coverage under several scenarios. Since the ultimate outcome will depend on states' own circumstances, they are meant as an illustration of a potential outcome that could occur. Regardless of the particular point estimates presented in the study, it seems clear that repealing both the Medicaid entitlement and ending the Federal-state matching payment structure will decrease Medicaid enrollment relative to baseline projections by 2002.

Reductions in Medicaid coverage could have three types of consequences. First, persons who would have been covered by Medicaid may face both financial hardship and access problems. Medicaid, for example, is the largest payor of nursing home care. Since nursing home care costs

an average of $38,000, those in need of care and their families could be at serious financial risk without Medicaid coverage. Access to care is also problem for people without insurance. It is well documented that the uninsured often delay seeking care and have lower utilization of heath care services, possibly resulting in more serious health problems and higher uncompensated care costs for providers (OTA, 1992; Institute of Medicine, 1993).

A second consequence is the effect on state governments. While past Medicaid growth is unsustainable and has taken an increasingly larger proportion of state budgets, Federal support for growing health care costs has been critical in preventing that state share from being even greater. Without Federal funding that responds to changing needs, the state governments may find themselves with real costs, inadequate Federal funding, and even more pressure on their state budgets.

Third, providers and ultimately people with private insurance may feel the effect of reductions in Medicaid coverage. A report by the Council on the Economic Impact of Health Reform suggests that the Republican proposal will force states to reduce Medicaid coverage which will in turn increase the number of uninsured, uncompensated care for providers and cost-shifting to private patients (Thorpe et al., 1995). Given the fact that Medicaid pays for 13 percent of all national health expenditures (Burner & Waldo, 1995), it is not surprising that significant reductions in that spending will be felt throughout the system.

The President's Medicaid reform proposal preserves the entitlement and the financial partnership between states and the Federal government -- thus protecting coverage. Federal savings are achieved through a "per capita cap" and reductions in Disproportionate Share Hospital (DSH) payments. The per capita cap limits the growth in Federal Medicaid spending per beneficiary (Appendix D). By limiting Federal spending on a "per beneficiary basis", Federal payments increase when spending increases because of enrollment changes. This serves as an incentive for states to reduce costs, not coverage. The proposal also offers new flexibility for states in the management of their programs, including the elimination of the need for waivers for innovative delivery system changes (managed care and home and community-based care programs) and the repeal of the Boren amendment. Together, the flexibility and the per capita cap policies would allow states to reduce program spending while maintaining Medicaid's role as the safety net for nursing home residents, low-income seniors, children, pregnant women, and people with disabilities.

CHART 1

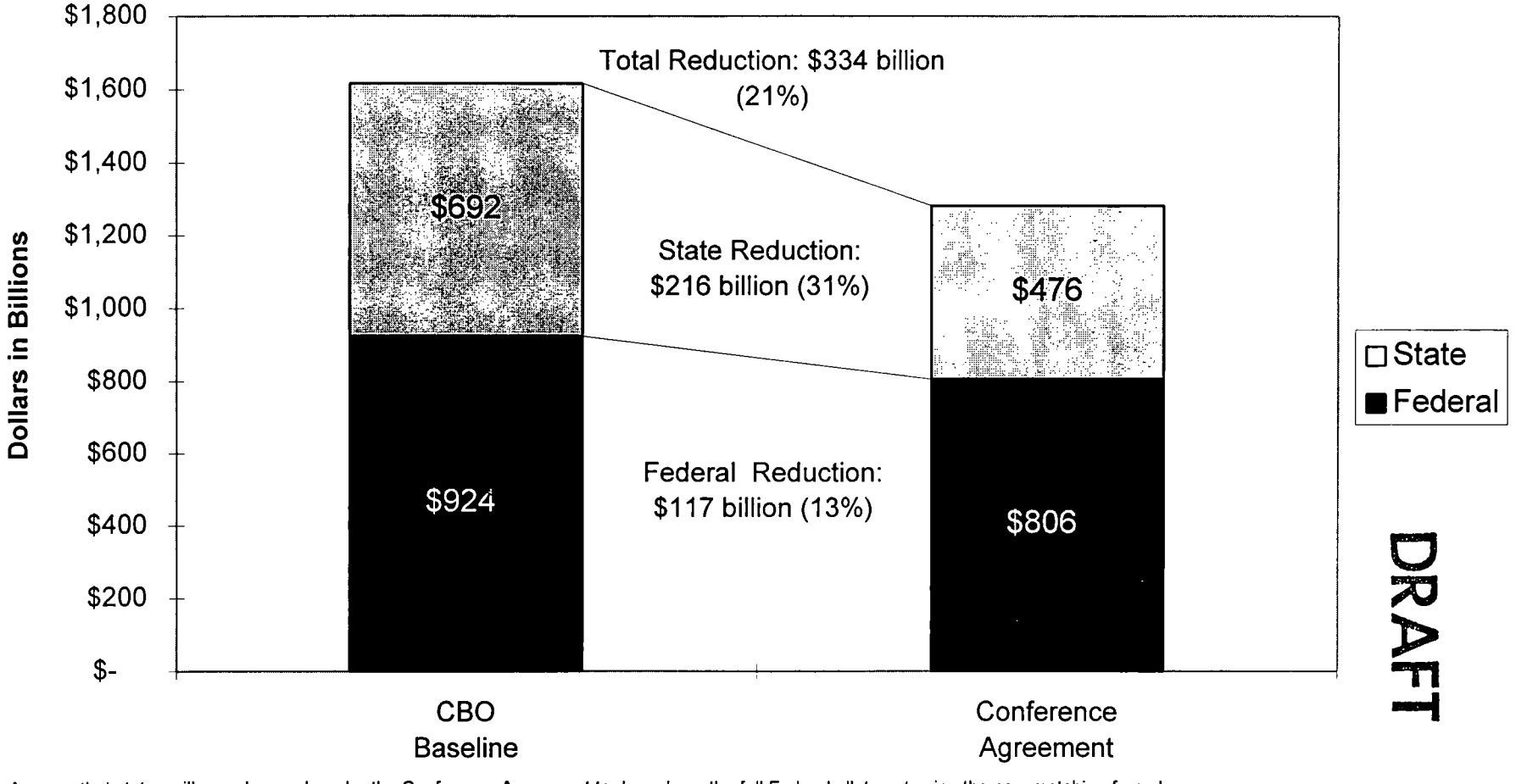
Medicaid Coverage in 1994

	Total	Aged	Disabled	Families	Children
Total	34,038,000	3,859,000	5,451,000	24,728,000	16,940,000
Alabama	539,000	72,000	126,000	342,000	243,000
Alaska	69,000	4,000	6,000	58,000	39,000
Arizona	509,000	58,000	81,000	370,000	255,000
Arkansas	339,000	52,000	84,000	202,000	140,000
California	5,008,000	513,000	709,000	3,785,000	2,357,000
Colorado	289,000	37,000	41,000	211,000	145,000
Connecticut	344,000	37,000	50,000	258,000	176,000
Delaware	75,000	6,000	11,000	58,000	42,000
District of Colum	127,000	9,000	22,000	96,000	67,000
Florida	1,727,000	204,000	251,000	1,272,000	1,011,000
Georgia	1,074,000	104,000	179,000	791,000	538,000
Hawaii	119,000	13,000	18,000	89,000	60,000
Idaho	110,000	9,000	17,000	84,000	59,000
Illinois	1,441,000	116,000	260,000	1,065,000	749,000
Indiana	602,000	70,000	67,000	465,000	318,000
Iowa	302,000	38,000	47,000	217,000	145,000
Kansas	251,000	27,000	37,000	188,000	127,000
Kentucky	637,000	65,000	151,000	420,000	279,000
Louisiana	757,000	97,000	136,000	524,000	373,000
Maine	177,000	23,000	34,000	120,000	80,000
Maryland	415,000	46,000	81,000	287,000	204,000
Massachusetts	704,000	103,000	137,000	464,000	309,000
Michigan	1,187,000	84,000	213,000	890,000	571,000
Minnesota	413,000	53,000	65,000	295,000	202,000
Mississippi	537,000	66,000	121,000	350,000	253,000
Missouri	669,000	90,000	92,000	487,000	321,000
Montana	95,000	9,000	15,000	71,000	39,000
Nebraska	159,000	20,000	22,000	117,000	87,000
Nevada	92,000	11,000	11,000	70,000	48,000
New Hampshire	83,000	10,000	13,000	60,000	41,000
New Jersey	782,000	87,000	138,000	557,000	364,000
New Mexico	264,000	18,000	34,000	212,000	144,000
New York	2,903,000	367,000	471,000	2,065,000	1,484,000
North Carolina	983,000	138,000	113,000	732,000	480,000
North Dakota	63,000	11,000	9,000	43,000	30,000
Ohio	1,496,000	161,000	220,000	1,115,000	760,000
Oklahoma	388,000	52,000	52,000	284,000	198,000
Oregon	411,000	39,000	53,000	320,000	213,000
Pennsylvania	1,255,000	143,000	264,000	849,000	611,000
Rhode Island	191,000	36,000	37,000	118,000	80,000
South Carolina	483,000	76,000	88,000	319,000	228,000
South Dakota	72,000	9,000	12,000	50,000	36,000
Tennessee	934,000	105,000	203,000	626,000	447,000
Texas	2,514,000	309,000	251,000	1,954,000	1,397,000
Utah	157,000	9,000	17,000	130,000	87,000
Vermont	94,000	10,000	14,000	69,000	44,000
Virginia	642,000	85,000	97,000	460,000	322,000
Washington	668,000	54,000	101,000	513,000	333,000
West Virginia	366,000	35,000	67,000	264,000	159,000
Wisconsin	472,000	67,000	105,000	301,000	221,000
Wyoming	50,000	5,000	6,000	40,000	28,000

Numbers may not sum to totals due to rounding

CHART 2

Medicaid Spending Under the Conference Agreement: 1996 - 2002



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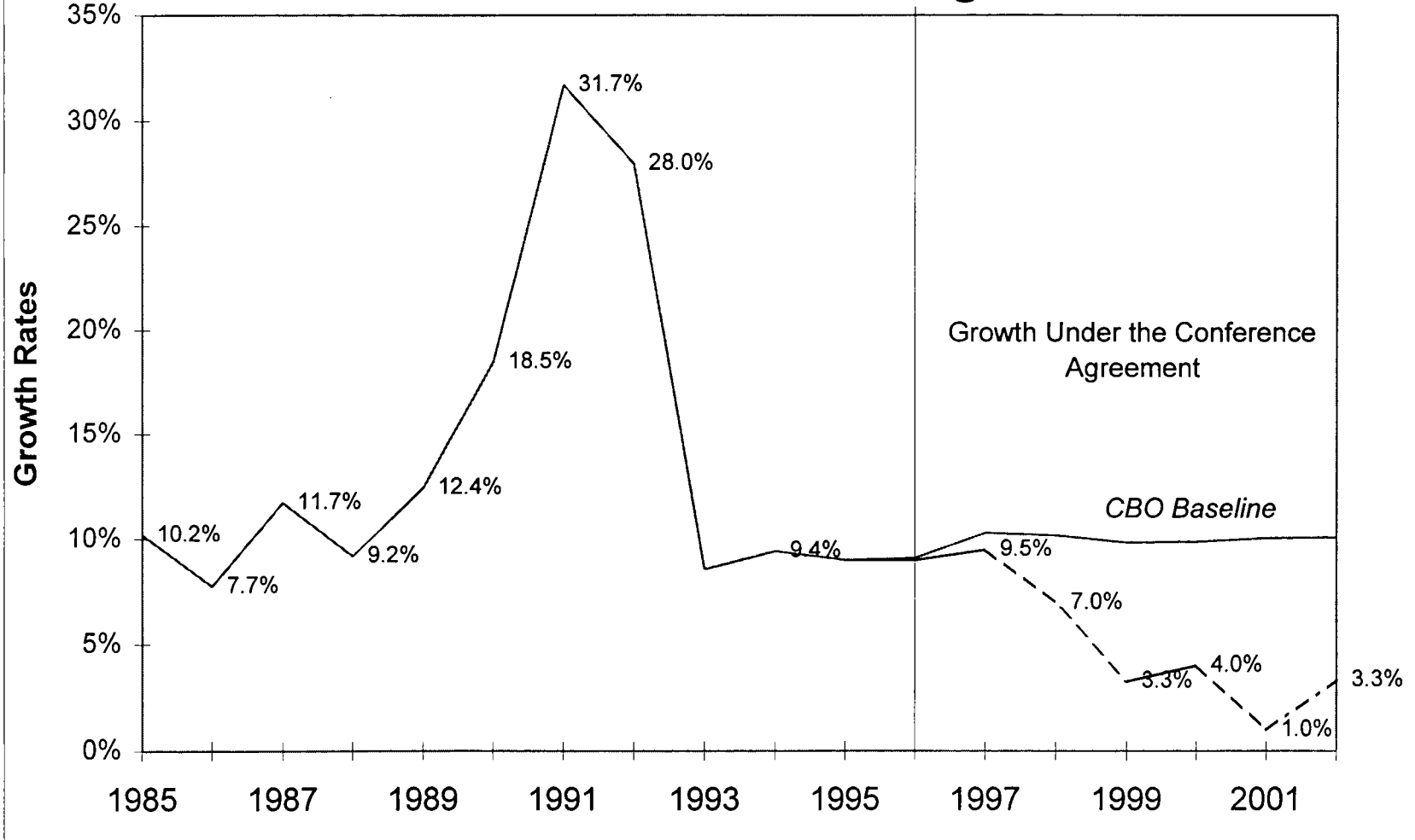
Assume that states will spend enough under the Conference Agreement to draw down the full Federal allotment using the new matching formula.
Numbers may not sum to totals due to rounding.

Chart 3

Medicaid Expenditure Growth: Historical and Under the Conference Agreement



Conference Agreement: Assumes savings of $117 billion between 1996 - 2002.

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CHART 4

Effects of the Conference Agreement Block Grant on Medicaid Coverage Loss in 2002

Assumes 1996 - 2002 Savings of $117 billion (Upper-Bound Estimate)

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	Total	Aged	Disabled	Families	Children
Total	**8,559,000**	**557,000**	**1,507,000**	**6,496,000**	**4,461,000**
Alabama	0	0	0	0	0
Alaska	24,000	1,000	2,000	21,000	14,000
Arizona	73,000	5,000	13,000	55,000	38,000
Arkansas	27,000	3,000	8,000	15,000	11,000
California	1,070,000	60,000	151,000	859,000	535,000
Colorado	96,000	7,000	16,000	72,000	50,000
Connecticut	159,000	10,000	24,000	126,000	86,000
Delaware	19,000	1,000	3,000	15,000	11,000
District of Columbia	60,000	3,000	12,000	45,000	32,000
Florida	490,000	34,000	70,000	385,000	306,000
Georgia	347,000	17,000	60,000	270,000	183,000
Hawaii	51,000	3,000	8,000	39,000	27,000
Idaho	*	*	*	0	*
Illinois	500,000	22,000	90,000	388,000	273,000
Indiana	218,000	14,000	23,000	181,000	124,000
Iowa	39,000	4,000	7,000	28,000	19,000
Kansas	29,000	2,000	5,000	22,000	15,000
Kentucky	167,000	12,000	50,000	105,000	70,000
Louisiana	486,000	41,000	116,000	328,000	233,000
Maine	54,000	4,000	12,000	38,000	26,000
Maryland	145,000	9,000	34,000	102,000	72,000
Massachusetts	287,000	22,000	52,000	213,000	142,000
Michigan	218,000	8,000	44,000	166,000	106,000
Minnesota	141,000	10,000	29,000	101,000	69,000
Mississippi	7,000	0	2,000	5,000	4,000
Missouri	26,000	2,000	4,000	21,000	14,000
Montana	20,000	1,000	4,000	16,000	9,000
Nebraska	36,000	3,000	6,000	27,000	20,000
Nevada	20,000	2,000	3,000	15,000	11,000
New Hampshire	78,000	6,000	14,000	58,000	40,000
New Jersey	329,000	25,000	71,000	233,000	153,000
New Mexico	0	0	0	0	0
New York	1,248,000	79,000	212,000	957,000	687,000
North Carolina	358,000	34,000	43,000	281,000	184,000
North Dakota	4,000	1,000	1,000	3,000	2,000
Ohio	74,000	5,000	12,000	57,000	39,000
Oklahoma	0	0	0	0	0
Oregon	23,000	1,000	3,000	20,000	13,000
Pennsylvania	338,000	21,000	82,000	235,000	170,000
Rhode Island	74,000	7,000	15,000	51,000	34,000
South Carolina	36,000	4,000	8,000	25,000	18,000
South Dakota	0	0	0	0	0
Tennessee	143,000	9,000	34,000	101,000	72,000
Texas	318,000	23,000	38,000	257,000	183,000
Utah	8,000	0	1,000	7,000	5,000
Vermont	19,000	1,000	3,000	15,000	9,000
Virginia	258,000	20,000	45,000	193,000	135,000
Washington	310,000	13,000	48,000	248,000	161,000
West Virginia	110,000	6,000	24,000	79,000	48,000
Wisconsin	14,000	1,000	3,000	9,000	7,000
Wyoming	9,000	1,000	1,000	7,000	5,000

Numbers may not sum to totals due to rounding

* Indicates less than 1,000.

DHHS estimates based on the Medicaid Expenditure model developed by the Urban Institute. Controlled to CBO December baseline

GAO November 18 estimates of the Conference Agreement: Note: $16 b. added in Dec. 15 offer does not affect 2002 spending.

Assumes that states spend as much as they need to match their cap, using the new FMAP.

Children losing coverage based on the proportion of children in families in 1994

CHART 5

Medicaid Coverage Loss Under the Conference Agreement in 2002

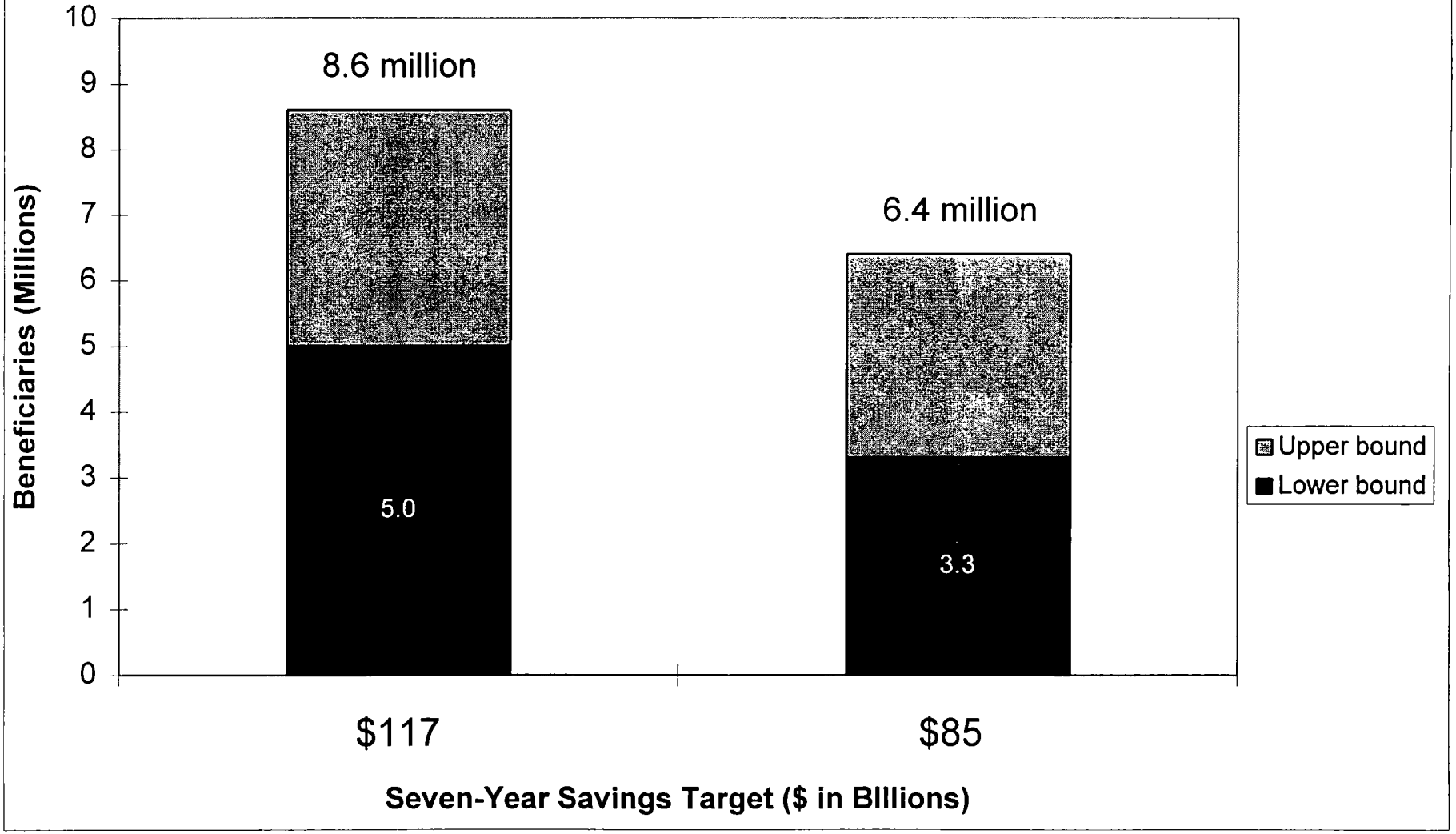

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CHART 6

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Comparison of Per Capita Growth Rates: Conference Agreement v. Current Law

		1995-2002		1995-2002		1995-2002
United States •	Baseline	6.7%	**United States**	6.7%	**United States**	6.7%
	Republicans	2.2%		2.2%		2.2%
Alabama	Baseline	6.3%	Kentucky	7.0%	North Dakota	7.0%
	Republicans	3.8%		2.5%		3.7%
Alaska	Baseline	6.8%	Louisiana	6.1%	Ohio	7.1%
	Republicans	3.2%		-4.9%		3.5%
Arizona	Baseline	7.6%	Maine	7.7%	Oklahoma	6.4%
	Republicans	3.0%		1.0%		5.9%
Arkansas	Baseline	7.3%	Maryland	7.2%	Oregon	7.5%
	Republicans	4.4%		2.8%		4.1%
California	Baseline	6.9%	Massachusetts	6.7%	Pennsylvania	6.5%
	Republicans	4.0%		1.6%		2.8%
Colorado	Baseline	4.4%	Michigan	7.9%	Rhode Island	7.4%
	Republicans	0.7%		3.5%		1.3%
Connecticut	Baseline	6.5%	Minnesota	8.9%	South Carolina	6.0%
	Republicans	0.9%		2.0%		3.0%
Delaware	Baseline	7.1%	Mississippi	7.6%	South Dakota	7.8%
	Republicans	4.5%		4.5%		4.4%
District of Columbia	Baseline	7.9%	Missouri	3.7%	Tennessee	5.0%
	Republicans	0.7%		1.5%		3.6%
Florida	Baseline	7.8%	Montana	6.6%	Texas	7.1%
	Republicans	4.2%		1.4%		2.3%
Georgia	Baseline	6.8%	Nebraska	8.5%	Utah	7.0%
	Republicans	0.4%		1.6%		4.0%
Hawaii	Baseline	7.6%	Nevada	5.5%	Vermont	6.6%
	Republicans	2.0%		4.0%		2.9%
Idaho	Baseline	6.0%	New Hampshire	2.6%	Virginia	6.1%
	Republicans	4.2%		-7.6%		2.0%
Illinois	Baseline	8.2%	New Jersey	5.7%	Washington	6.8%
	Republicans	3.4%		0.3%		0.4%
Indiana	Baseline	5.4%	New Mexico	7.1%	West Virginia	7.3%
	Republicans	0.3%		4.2%		1.0%
Iowa	Baseline	7.6%	New York	6.6%	Wisconsin	7.6%
	Republicans	3.3%		1.1%		4.6%
Kansas	Baseline	7.5%	North Carolina	6.1%	Wyoming	6.7%
	Republicans	3.1%		0.8%		2.6%

Baseline is based on HHS estimates using the Urban Institute's Medicaid Expenditure Baseline methods, adjusted to control to the CBO December baseline.
Republican spending from GAO's November 16 state tables, plus $16 billion in transition funds allocated to states in proportion to their allotments.
Assumes that enrollment growth in the Republican proposal is the same as baseline (no coverage loss).

CHART 7

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Estimates of the Effects of the Conference Agreement Medicaid Plan on States, 2002 and 1996 - 2002
(Dollars in Millions, Federal Spending, Fiscal Years)

States	2002				1996-2002			
	Dec Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	Dec. Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction
Total	$173,038	$127,233	($45,805)	-26%	$924,100	$805,980	($118,120)	-13%
Alabama	$2,547	$2,145	($402)	-16%	$13,847	$13,125	($722)	-5%
Alaska	$354	$275	($79)	-22%	$1,864	$1,693	($171)	-9%
Arizona	$2,647	$1,913	($734)	-28%	$13,854	$11,894	($1,960)	-14%
Arkansas	$1,737	$1,430	($307)	-18%	$9,226	$8,747	($479)	-5%
California	$16,608	$13,678	($2,930)	-18%	$89,944	$81,891	($8,053)	-9%
Colorado	$1,353	$1,030	($322)	-24%	$7,619	$6,497	($1,122)	-15%
Connecticut	$2,458	$1,688	($770)	-31%	$13,402	$11,321	($2,081)	-16%
Delaware	$339	$285	($54)	-16%	$1,783	$1,754	($29)	-2%
District of Columbi	$947	$579	($368)	-39%	$4,938	$3,880	($1,059)	-21%
Florida	$7,338	$5,680	($1,658)	-23%	$37,956	$33,702	($4,254)	-11%
Georgia	$5,129	$3,301	($1,828)	-36%	$26,513	$20,763	($5,750)	-22%
Hawaii	$518	$373	($145)	-28%	$2,713	$2,500	($213)	-8%
Idaho	$483	$426	($58)	-12%	$2,604	$2,498	($106)	-4%
Illinois	$6,528	$4,684	($1,844)	-28%	$34,174	$29,644	($4,530)	-13%
Indiana	$3,750	$2,589	($1,160)	-31%	$20,178	$16,396	($3,782)	-19%
Iowa	$1,471	$1,108	($363)	-25%	$7,870	$7,014	($856)	-11%
Kansas	$1,231	$946	($284)	-23%	$6,480	$5,993	($487)	-8%
Kentucky	$3,081	$2,230	($851)	-28%	$16,314	$13,645	($2,668)	-16%
Louisiana	$6,100	$2,909	($3,191)	-52%	$32,767	$19,195	($13,571)	-41%
Maine	$1,253	$801	($452)	-36%	$6,646	$5,372	($1,274)	-19%
Maryland	$2,474	$1,810	($664)	-27%	$13,201	$11,495	($1,706)	-13%
Massachusetts	$4,704	$3,312	($1,392)	-30%	$25,457	$22,260	($3,197)	-13%
Michigan	$6,166	$4,595	($1,571)	-25%	$32,560	$29,099	($3,460)	-11%
Minnesota	$3,271	$2,070	($1,201)	-37%	$17,047	$13,880	($3,167)	-19%
Mississippi	$2,396	$1,929	($467)	-19%	$12,527	$11,323	($1,204)	-10%
Missouri	$2,873	$2,484	($389)	-14%	$16,065	$15,650	($414)	-3%
Montana	$600	$422	($177)	-30%	$3,119	$2,656	($463)	-15%
Nebraska	$864	$542	($321)	-37%	$4,569	$3,735	($834)	-18%
Nevada	$435	$394	($41)	-9%	$2,341	$2,584	$243	10%
New Hampshire	$756	$375	($381)	-50%	$4,369	$2,593	($1,776)	-41%
New Jersey	$4,853	$3,294	($1,559)	-32%	$26,735	$22,218	($4,518)	-17%
New Mexico	$1,180	$970	($209)	-18%	$6,161	$5,717	($444)	-7%
New York	$21,375	$14,888	($6,487)	-30%	$115,961	$100,332	($15,628)	-13%
North Carolina	$4,936	$3,432	($1,504)	-30%	$25,800	$21,732	($4,068)	-16%
North Dakota	$398	$320	($78)	-20%	$2,161	$2,025	($136)	-6%
Ohio	$6,911	$5,350	($1,561)	-23%	$37,364	$33,877	($3,487)	-9%
Oklahoma	$1,443	$1,393	($49)	-3%	$7,906	$8,177	$271	3%
Oregon	$1,819	$1,444	($375)	-21%	$9,449	$9,165	($284)	-3%
Pennsylvania	$7,564	$5,818	($1,746)	-23%	$40,888	$36,910	($3,978)	-10%
Rhode Island	$954	$630	($324)	-34%	$5,163	$4,222	($941)	-18%
South Carolina	$2,799	$2,291	($508)	-18%	$15,096	$14,019	($1,077)	-7%
South Dakota	$435	$349	($86)	-20%	$2,316	$2,207	($109)	-5%
Tennessee	$3,558	$3,342	($216)	-6%	$19,269	$21,162	$1,893	10%
Texas	$12,601	$9,102	($3,500)	-28%	$65,336	$56,390	($8,946)	-14%
Utah	$836	$683	($153)	-18%	$4,494	$4,186	($307)	-7%
Vermont	$405	$305	($100)	-25%	$2,153	$1,958	($195)	-9%
Virginia	$2,150	$1,607	($543)	-25%	$11,365	$10,035	($1,330)	-12%
Washington	$3,157	$2,035	($1,122)	-36%	$16,644	$13,679	($2,965)	-18%
West Virginia	$2,260	$1,534	($726)	-32%	$11,703	$9,715	($1,989)	-17%
Wisconsin	$2,761	$2,267	($494)	-18%	$14,935	$14,356	($579)	-4%
Wyoming	$235	$178	($57)	-24%	$1,254	$1,098	($156)	-12%

(1) The Urban Institute Medicaid Baseline, December 1995; controlled to the December CBO baseline.

(2) From the GAO estimates of the block grant allocation of the Conference Agremeent proposal, as of November 16, 1995

Note: These estimates include supplemental payments for illegal aliens, Nebraska, Nevada & Louisiana. Excludes territories.

Note: No allocation formula was released for the $16 b transition pool announced on December 15; pool payments were allocated to states in proportion to their block grant allotment. Excludes Territories; thus, savings are slightly higher than the CBO score of $117 billion.

CHART 8

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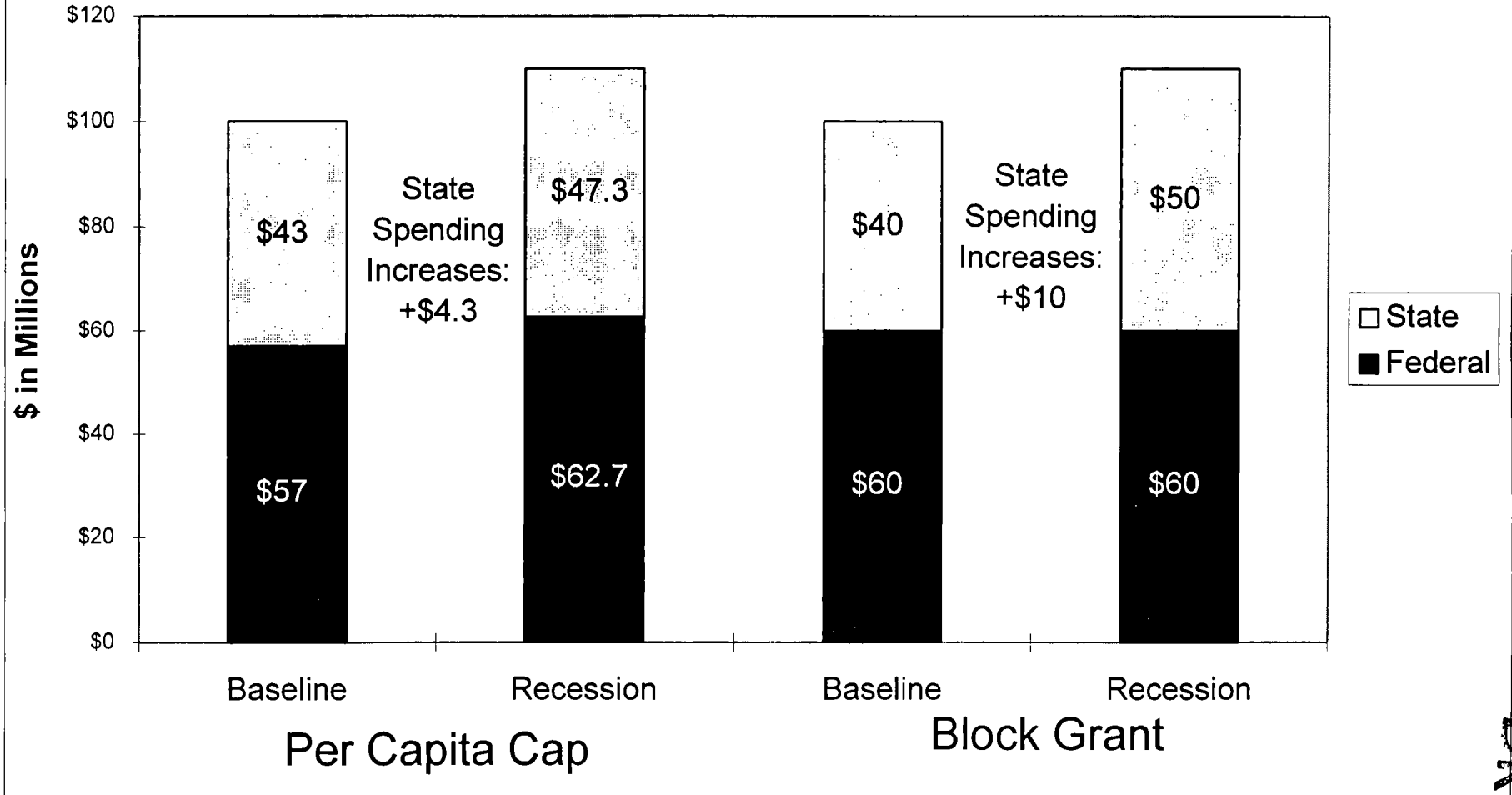
Change in the Matching Rate Under The Republican Conference Agreement

	Current (96)	Proposed
Total	**57%**	**63%**
Alabama	69.85%	72.92%
Alaska	50.00%	60.00%
Arizona	65.85%	65.85%
Arkansas	73.61%	74.11%
California	50.00%	60.00%
Colorado	52.44%	60.00%
Connecticut	50.00%	60.00%
Delaware	50.33%	60.00%
District of Columbia	50.00%	60.00%
Florida	55.76%	65.70%
Georgia	61.90%	61.90%
Hawaii	50.00%	60.00%
Idaho	68.78%	68.78%
Illinois	50.00%	60.00%
Indiana	62.57%	62.57%
Iowa	64.22%	64.22%
Kansas	59.04%	60.00%
Kentucky	70.30%	74.73%
Louisiana	71.89%	77.13%
Maine	63.32%	65.16%
Maryland	50.00%	60.00%
Massachusetts	50.00%	60.00%
Michigan	56.77%	61.22%
Minnesota	53.84%	60.00%
Mississippi	78.07%	80.74%
Missouri	60.06%	60.49%
Montana	69.38%	69.38%
Nebraska	59.49%	60.00%
Nevada	50.00%	60.00%
New Hampshire	50.00%	60.00%
New Jersey	50.00%	60.00%
New Mexico	72.87%	72.95%
New York	50.00%	60.00%
North Carolina	64.59%	64.59%
North Dakota	69.06%	69.06%
Ohio	60.17%	60.17%
Oklahoma	69.89%	69.89%
Oregon	61.01%	61.01%
Pennsylvania	52.93%	60.00%
Rhode Island	53.84%	60.00%
South Carolina	70.77%	74.04%
South Dakota	66.66%	66.66%
Tennessee	65.64%	69.61%
Texas	62.30%	62.75%
Utah	73.21%	73.21%
Vermont	60.87%	60.87%
Virginia	51.37%	60.00%
Washington	50.19%	60.00%
West Virginia	73.26%	75.76%
Wisconsin	59.67%	60.00%
Wyoming	59.69%	60.00%

"Current" is the FY 1996 FMAP; "Proposed" comes from General Accounting Office (December 1995).
Note. NH and LA get special matching rate treatment.

Chart 9

Effect of Increased Medicaid Costs on State Spending
Example: What if Total Costs Increased by $10 million?



Assumes matching rate of 57% for matching program and 60% for the block grant.

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APPENDIX A. Formula under the Conference Agreement

FEDERAL SPENDING:

Spending: Federal spending is fixed by a formula to sum to $807 billion over seven years, including:

- Payments for medical assistance ($791 billion);
- Payments for Transition Pool ($16 billion);
- Payments for emergency health services for certain aliens ($3.5 billion); &
- Special payments for Louisiana, Nebraska, and Nevada ($413 million).

Savings: $117 billion over 7 years [preliminary estimate from CBO's December baseline]

STATE ALLOCATION:

1996: The 1996 allotments to states are fixed in the legislation. There is no explanation for the derivation of these amounts.

Subsequent years:

State allotments in subsequent years are based on a "needs-based amount", which is basically the number of people in poverty in a state multiplied by a state-adjusted per capita cost. This amount is subject to three constraints: (1) the allotment growth over the previous year's allotment cannot exceed a certain level (ceiling); (2) the allotment growth over the previous year's allotment cannot be less than a certain level (floor); and (3) all states allotments are summed to control to the pool amount set in legislation.

Floors: The floor is the maximum of: (1) the previous year's allotment increased by 3.5% in 1997, 3.0% in 1998, and 2.0% in subsequent years.; (2) 0.24% of the total Federal pool for all states for that year, beginning in 1998; or (3) for states with FY 1998 growth that exceeds the national pool growth, a growth rate of 4.0%, beginning in 1998.

General Floor (about 2%):	Connecticut, DC, Hawaii, Maine, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Rhode Island, Vermont*, Washington
Higher Floor (about 4%):	Illinois *, Iowa, Indiana, Kansas, Maryland, Michigan, Missouri, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, West Virginia, Wisconsin.

Ceilings: For most states, growth in the allotment cannot exceed 9% in 1997 and 5.33% in subsequent years. For the states whose MediGrant per poor person is among the 10 lowest in the nation, the allotment growth cannot exceed 7.0%, beginning in 1998.

General Ceiling (about 5.3%):	Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Kentucky, Montana *, South Carolina, Utah, Wyoming
Higher Ceiling (about 7%):	California, Florida, Idaho, Mississippi, Nevada, New Mexico, Oklahoma, Texas, Virginia

Exceptions: Louisiana shall get $2.622 billion each year between 1997 and 2000; New Hampshire shall get $360 million each year between 1997 and 2000.

No state has its Federal grant determined only by the "needs-based formula" as described in the legislation for every year. States with asterisks have one or several years of growth determined by the formula or the small-state minimum. New Hampshire and Louisiana get special treatment -- they get a large reduction and no growth until after 2000 in exchange for a lower state share.

APPENDIX B. State Matching Rates Under the Conference Agreement

Meaning of Matching Rates in a "Match to a Cap". Under the Conference Agreement, states and the Federal government share in program costs using a matching formula until Federal payments reach an allotment or "cap". Once a state receives its Federal allotment, all additional costs are borne by the state, meaning a 0% Federal matching rate. Thus, the matching rate does not necessarily describe the percent of total costs paid for by the Federal government. For instance, if a state's total costs were $100 million, its matching rate were 50%, and its Federal cap were $50 million, then the Federal government is still paying 50% of costs under the proposal. However, if the total costs were $200, the Federal cap would still be $50 million, which is only 25% of total costs. The matching rate of 50% is thus relevant only to determine how much a state has to spend to draw down its cap, before its matching rate becomes 0%.

Change in the Matching Rate. The Conference Agreement allows states the choice of the three possible matching percentages (Chart 8).

1. The current Federal medical assistance percentage (FMAP) based on the states' per capita income relative to the national per capita income;

2. A new Federal matching percentage based on total taxable resources and "need" (constrained so that the difference between this matching percentage and the current matching percentage is no greater than 10%); and

3. 60 percent (GAO, December 1995).

The current formula has been used since the 1960s. Critics have suggested that it does not accurately reflect a state's ability to pay for Medicaid, which is one of the objectives of a matching formula (Blumberg et al., 1995; GAO, 1993).

The new Federal matching percentage has two components: the states' share of total taxable resources -- a measure of a state's fiscal capacity -- and the states' share of "need". Need in this formula is equal to the number of people in poverty in a state times the national average Medicaid spending per beneficiary, adjusted for state-specific health costs and case mix. This measure intends to capture both a state's ability to pay and the demand in the state for Medicaid.

Result of the change in matching rates. Since states will choose the highest of the matching rates, the new floor under the proposal is 60 percent rather than the current 50 percent. Another 14 states get higher matching rates as a result of the move to the new formula (GAO, December 1995). At the national level, this means that the Federal government no longer pays for 57 percent of total costs -- it pays 63 percent of costs.

To get a sense of the magnitude of this shift in state and Federal spending, assume that the new formula were applied in 1995. In that year, CBO estimates that total Medicaid spending is about

$156 billion, and Federal spending is $89 billion. If this new matching rate were in effect, the Federal government would spend $98 billion, an increased Federal cost of about 10 percent.

This change in the matching rate has no effect on Federal spending in the context of a block grant since maximum Federal payments are fixed. Instead, it allows the states to spend less to draw down Federal payments. According CBO estimates, Federal spending is reduced by $117 billion over the period, or around 13 percent. If the matching rate were not changed, then states could also reduce their spending by 13 percent in order to draw down their maximum Federal allotment. However, the matching rate is changed under the proposal so that the stateshare is lowered. Since the Federal share is fixed under the block grant, this does not mean that the Federal payments increase -- it means that states can spend 31 percent less to draw down the maximum Federal funding.

APPENDIX C. Effect of Increases in Medicaid Costs on States Under a Block Grant

- **From a Federal perspective, a major advantage of the Medicaid block grant is its predictable spending.** The amount that the Federal government will spend on Medicaid in the next seven years is set in statute and cannot exceed the budgeted amount.

- **From the states' perspective, however, this may be not be seen as an advantage.**

    - Medicaid costs have historically been unpredictable. This results because Medicaid costs are effected by cycles in the economy; unexpected demographic trends such as the AIDS outbreak and the growing number of people older than 85 years; and changes in state and Federal policy.

    - Granting states flexibility to spend the limited Federal funding may help states better target their dollars, but flexibility in spending does not change the underlying, unpredictable nature of health care costs.

- **States are fully liable for any unexpected cost increases**. To illustrate what might happen to a state if costs are higher than expected, take an example of a hypothetical state whose total Medicaid costs are $100 million (see Chart 9). Its matching rate is 57 percent under a per capita cap, and 60 percent under the block grant. If a severe recession hits or some other event occurs that causes the actual program costs to be $10 million higher than predicted:

    - **The Federal spending stays the same under the block grant but increases under the per capita cap program.** Because the per capita cap program means that the Federal government pays a percentage of total costs, its spending increases by $5.7 million when the recession hits. Under the block grant, however, the Federal spending is fixed and, in fact, becomes a smaller share of program costs as the program costs increase.

    - **The state spending increases under both a per capita cap and block grant, but increases more under the block grant.** The state spending under the per capita cap is protected by the matching rate, so that its costs only increase by $4.3 million. Under the block grant, however, its spending is dollar-for-dollar increased with total costs. Thus, the $10 million increase in costs creates a $10 million increase in state spending.

- **State spending could increase by $7 billion to $26 billion over the next seven years if a recession occurs, according to the Center on Budget and Policy Priorities.** The Center also used CBO "rules of thumb" to estimate that states could have to pay an additional $69 billion if inflation is 1 percentage point higher than CBO projects for the next seven years (Mann & Kogan, 1995).

APPENDIX D: Medicaid Per Capita Cap

- **Per capita cap.** A "per capita cap" is a policy that limits Federal Medicaid spending growth on a per person basis. The Federal payments under this policy automatically adjust to a state's enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in the costs for that population.

- **Formula**: The proposed formula retains the current Federal matching structure, but limits the Federal Medicaid spending growth per beneficiary. The limit is calculated by:

  1. **Calculating the 1995 Federal and state spending per beneficiary**, by beneficiary group, for each state. The four groups are: adults; children; aged; and disabled. Calculating the limit by group allows it to adapt to changes in the type of beneficiaries enrolled in a state;

  2. **Multiplying the 1995 spending per beneficiary by an "index"**, which would be set in the legislation. The index is a factor that is based on some measure of inflation such as the CPI or nominal gross domestic product growth per person. This is used to allow the base year spending per person to keep up with inflation.

  3. **Multiplying the indexed spending per beneficiary by the number of beneficiaries in that year.** The limit is the total spending amount that the Federal government will match. By multiplying the indexed spending per beneficiary by the number of beneficiaries, the limit increases or decreases depending on total enrollment and enrollment mix in that year. These group-specific limits would then be summed for the state; and

  4. **Multiplying the cap by the Federal matching rate (FMAP).** Once the limit is determined, it is multiplied by the FMAP to determine the maximum Federal spending.

APPENDIX E: Urban Institute Baseline and Adjustments

The analyses described in this paper are based on Department of Health and Human Services adjustments to the Urban Institute's state Medicaid expenditures baseline. The Urban Institute has created a model that projects beneficary and expenditure growth from 1994 to 2005. Basically, it does this in a series of steps. First, national growth rates are projected for enrollment and spending per beneficiary by seven different eligibility groups and for acute care and long-term care separately. Second, the national rates are adjusted for state-specific historical trends for each of these groups and types of services. These state-specific adjusters are phased out over time, so that all states grow at the national average rates in the later years. Third, the sum of the state projections are controlled to the Congressional Budget Office's December 1995 baseline, at the direction of the Department of Health and Human Services.

For a more detailed description of the baseline, please see Holahan and Liska's 1995 reports.