CENTER ON BUDGET AND POLICY PRIORITIES

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AN ILLUSORY STATE MATCH REQUIREMENT?

The Republican Medicaid Proposals Bring Back State Financing Gimmicks

by Cindy Mann

The House Commerce Committee Medicaid bill and the Senate Finance Committee Chairman's mark purport to create a block grant program that would require states to spend state funds for medical assistance and related services as a condition of receiving their capped allotment of federal "Medigrant" dollars. However, the bills would allow states complete discretion to determine how they will finance their share of the expenditures. They repeal the Medicaid financing reforms ushered in by the Bush Administration and permit states to resurrect discredited financing schemes that allowed them to claim federal matching dollars based on illusory state spending. As a result, the requirement of a state match in these bills is itself illusory.

Accounts of state abuses in Medicaid financing schemes that had been permitted under former federal Medicaid law are well documented. Between 1989 and 1992 many states made use of financing methods, such as questionable disproportionate share hospital payments, provider "donations" and taxes, and intergovernmental transfers to draw down federal Medicaid funds. Although the use of these financing methods varied widely among states, some states took advantage of them to claim federal Medicaid matching funds without actually spending state dollars, for example by using borrowed funds collected through provider "donations" that were then returned to the providers. (See box for examples.) In the words of CBO, these financing mechanisms allowed states to claim federal dollars "for what were often illusory Medicaid expenditures"[1].

As a result, large new costs were shifted to the federal government, and Medicaid expenditures grew rapidly. Between 1989 and 1992, federal disproportionate share ("DSH") spending grew from $400 million to $10.1 billion. By 1993, DSH payments accounted for 13 percent of all Medicaid spending, or one out of

[1] CBO Testimony, Statement of June E. O'Neill, Director, Congressional Budget Office, Committee on Finance, U.S. Senate, June 29, 1995. Some states did use DSH funds appropriately to help hospitals and other providers that provided large amounts of uncompensated care to uninsured low-income people. See, generally, Leighton Ku and Teresa Coughlin, *Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government*, December 1994.

every seven dollars spent in the Medicaid program — more than all spending for physician services and prescription medications combined. President Bush and Congress responded to these questionable financing methods and high growth rates by limiting the use of provider taxes and capping the amount of disproportionate share payments that states could receive. As a result of these reforms, CBO projects that under current law, DSH payments will increase by five percent annually through 1999 and by only 2 percent annually from 1999 through 2002.

The reforms and carefully crafted compromises that have successfully limited these financing practices would be repealed by the Medicaid proposals approved by the House Commerce Committee and proposed in the Senate Finance Committee. States would be free to revive these practices and develop new ones to limit state spending while assuring that they received the maximum allotment of federal dollars that would be available to them under the Medicaid block grant.[2]

In fact, states would be even more inclined to experiment with such practices in the future than they have been in the past. At the same time that states will be experiencing deep cuts in federal Medicaid payments, they will be facing substantial reductions in other federal grants on which they rely to help finance highway projects, welfare, education and a wide range of other state and local services. States will be under heavy fiscal pressure to use provider donations and taxes, intergovernmental transfers and other mechanisms help them to draw down their maximum allotment of federal block grant dollars while limiting state expenditures.

In the past, these financing methods led to rapid increases in federal Medicaid spending, often for purposes that had little if anything to do with the goals of the program. These schemes were costly to the federal government, although they were not injurious to program beneficiaries. Under the proposed block grant, the harm caused by such practices would shift from the federal treasury to low-income families and elderly and disabled individuals. Because the federal government's exposure is capped under a block grant, creative financing schemes could not result in higher-than-anticipated federal spending. States would engage in these practices not to increase their federal payments, but to limit their state spending. These schemes would therefore result in the loss of critical dollars for medical services, deepening the already very large cuts planned for the program through the sharp reduction in federal funding. The likely result would be further reductions in the number of low-income children, families and elderly and disabled people covered under Medicaid —

[2] In addition to provider donations, provider taxes and intergovernmental transfers, the block grant proposals appear to allow states to claim federal matching funds by simply recategorizing current state expenditures as the state's share under the block grant. Under this kind of financing scheme, for example, payments a state had been making to cover the cost of health insurance for state employees with incomes under 250 percent of the poverty line could be used to claim federal matching dollars.

with a corresponding increase in the ranks of the uninsured — and further cutbacks in the health services covered for those who retain Medicaid coverage.

Examples of How Special Medicaid Financing Methods Allowed States to Draw Down on Federal Dollars Without Spending State Funds

The following example illustrates how these financing methods worked in the past:

Assume a state imposed a provider tax that was paid by hospitals and that raised $40 million dollars. The state then pays back to the hospitals subject to the tax $50 million in disproportionate share hospital ("DSH") payments, which under the law are supposed to provide additional funds to hospitals that serve a disproportionately high number of Medicaid and low-income uninsured patients. If the state's federal Medicaid match rate is 50 percent, it can claim $25 million in federal Medicaid funds based on the $50 million in DSH payments to the hospitals.

The result: the hospitals gain $10 million ($50 million in DSH payments less the $40 million in provider taxes); the state gains $15 million ($25 million in federal matching funds plus $40 million in provider taxes minus $50 million in DSH payments); and the federal government pays $25 million without any net state funds having actually been expended.

Michigan's practices are instructive:

In fiscal year 1993, Michigan raised $452 million through hospital donations, and then paid the hospitals $458 million in disproportionate share (DSH) payments. Based on these payments, Michigan claimed $256 million in federal matching funds. The net effect of these transactions is as follows: the hospitals gained $6 million ($458 million in DSH funds less $452 million in provider donations); the state gained $250 million ($256 million in federal matching funds less $6 million in net payments to the hospitals); and the federal government paid $256 million in federal matching funds without any net state funds having been expended.

When provider donations were limited by Congress through legislation enacted in 1991 that became effective January 1, 1993, this loophole was closed. Michigan responded by relying on intergovernmental transfers and changing its criteria for deciding which hospitals would qualify for DSH payments, a determination that former law left almost entirely to state discretion. In October, 1993, it paid $489 million to the one hospital that met its new DSH definition — the state-owned University of Michigan hospital. The state claimed $276 million in federal matching funds for this payment, but the public hospital returned the full $489 payment to the state through an intergovernmental transfer the very same day that the payment was made. Through this one transaction, Michigan realized a net gain of $276 million in federal Medicaid payments, again without having to spend any state funds. This practice has now also been limited by Congress through provisions phased-in beginning in July 1994.

Source: GAO, *States Use Illusory Approaches to Shift Program Costs to Federal Government*, August 1994.

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THE FINANCING METHOD MAKES A DIFFERENCE: A MEDICAID BLOCK GRANT WOULD SHIFT *ALL* UNANTICIPATED COSTS TO STATES

A block grant and a *per capita* cap each could be designed to achieve the same level of savings — whatever level of federal savings is targeted — using CBO economic assumptions. But under a block grant, if Medicaid costs over the next seven years are higher than CBO projects, *all* of the additional costs would be shifted to states. In contrast, under a *per capita* cap, these additional costs are shared by the federal government and the states. The Center on Budget and Policy Priorities has projected how much cost shift there will be under three different economic assumptions. (See table on reverse.)

A recession would increase Medicaid costs because a recession would result in more low-income uninsured families who would qualify for coverage under the program. If there is a mild recession beginning in 1996, like the one that occurred in 1991-1992, Medicaid costs can be expected to rise by $7 billion above current projections between 1996 - 2002. If there is a severe recession beginning in 1996, like the one that occurred in the early 1980's, Medicaid costs can be expected to rise by about $29 billion over the seven-year period.

- Under a block grant with an aggregate cap, *states would be responsible for the entire $7 billion or $29 billion* in additional enrollment-related costs.

- Under a *per capita* cap, enrollment-related costs would be shared almost equally between the federal government and the states.

If inflation is one percent higher than projected by CBO for each year beginning in 1996, Medicaid costs can be expected to increase by $65 billion over the next seven years as compared with current CBO projections.

- Under a block grant with an aggregate cap, *states would be responsible for the entire $65 billion* in additional inflation-related costs

- Under a *per capita* cap, inflation-related costs would be shared by the federal government and the states. States would pay about $32 billion and the federal government would pay about $33 billion of the added costs.

The large cost shift to states that would occur if inflation were higher than predicted or if enrollment rose due to an economic downturn would add to the fiscal pressures states will experience in any case because of sharply reduced federal Medicaid spending. States that are unable to assume these additional costs would have to restrict eligibility and services to an even greater degree than would be required by the proposed reduction in funding. A *per capita* cap that is set at a level designed to cut federal Medicaid spending deeply over seven years also would cause great hardship to states and to the persons served by their Medicaid programs. A *per capita* cap, however, would keep the federal government as a partner sharing the additional costs that would result from a recession or higher-than-anticipated inflation, and it would, therefore, limit the pressure states will experience under a block grant to dramatically cutback on services and coverage.

Responses of Different Funding Arrangements[1]
to Changes in Medicaid Costs
(dollars in billions, 1996-2002)

Cause of Cost Increase	Increase in Total Costs	Distribution of Increased Costs Under Current Law		After $182 Billion in Federal Cuts			
				Distribution of Additional Costs Under an Aggregate Cap		Distribution of Additional Costs Under a *Per Capita* Cap	
		Federal	State	Federal	State	Federal	State
Mild Recession	$ 7.8	$ 4.5	$ 3.4	0	$ 7.8	$ 4.3	$ 3.5
Severe Recession	29.2	16.7	12.6	0	29.2	14.9	14.4
Extra Inflation	64.7	36.9	27.8	0	64.7	32.8	31.9

[1] These calculations and the financing methods analyzed here are explained *Comparing the Options for Achieving Federal Medicaid Savings*, Center on Budget and Policy Priorities, July 13, 1995. In general, the aggregate cap assumes the level of growth in federal Medicaid spending specified in the Budget Resolution and applies that growth rate to 1995 Medicaid payments, including disproportionate share (DSH) payments. The *per capita* cap alternative assumes a DSH reform although this aspect of the alternative does not significantly affect the seven-year impact on states described here.

CENTER ON BUDGET AND POLICY PRIORITIES

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STATE-BY-STATE EFFECTS OF FEDERAL MEDICAID CUTS: A COMPARISON OF CONGRESSIONAL PLANS

by Richard Kogan and Myra Tanamor

Approximately a week after the House Commerce Committee unveiled its plan to overhaul the present Medicaid system, the Senate Finance Committee presented a strikingly different scheme to allocate federal payments to states.

The attached table shows the estimated reduction in federal Medicaid spending to individual states in each fiscal year from 1996 to 2002 under the Senate Finance Committee plan. Similar to the House Commerce Committee plan, overall Medicaid spending would be reduced by 30 percent by the year 2002, relative to existing law. However, the plan proposed by the Senate Finance Committee reduces federal Medicaid payments to the states by an additional $4.3 billion, compared with the House Commerce Committee proposal. The Senate cut is deeper than envisioned in the budget resolution agreed to earlier this year.

Louisiana, Indiana, West Virginia, Washington, Connecticut and New Hampshire were affected most under the Senate Finance Committee plan. In 2002, federal Medicaid payments to Louisiana would be cut 53 percent, for example, and payments to Connecticut and New Hampshire, 41 percent.

Reductions were less severe for Oregon, California, South Dakota, Mississippi, Delaware, Minnesota, and Missouri. In theses states, by 2002, Medicaid cuts range from 15 percent for Oregon to 20 percent for Delaware, Minnesota, and Missouri.

Comparing the Senate Finance Committee and the House Commerce Committee Medicaid cuts shows very different formulas. As the third table illustrates, states cut more deeply by the Senate than the House are New Hampshire, Louisiana, Missouri, and Alabama. Those states whose Medicaid payments are cut less severely in the Senate Finance Committee plan include Delaware, Oregon, Alaska, and Minnesota.

The federal payments would be in the form of block grants to states. The proposed block grant formula in both congressional versions produces fixed dollar totals; the total amount of federal payments would not be responsive to cost changes such as those produced by an economic downturn or deviations from the expected inflation rate.

The estimates in the tables were derived from three documents. The first two are tables of year-by-year payments to states prepared by the General Accounting Office,

following the complex formulas described in the congressional plans. The third is a baseline projection of Medicaid payments to states under existing law, constructed by the Urban Institute in March 1995, and adjusted by the Center on Budget and Policy Priorities so that both disproportionate share hospital (DSH) program and non-DSH portions of Medicaid match aggregate DSH and non-DSH baseline projections by the Congressional Budget Office.

SENATE FINANCE MARK

Estimated Reduction in Federal Medicaid Spending
relative to CBO's projection of current law. In millions of dollars

	1996	1997	1998	1999	2000	2001	2002	7-yr Tot	Percent cut in 2002
Total	-5184	-9560	-17152	-25285	-33723	-43174	-53071	-187149	-30%
Alabama	-191	-214	-287	-365	-439	-524	-610	-2631	-25%
Alaska	-9	-18	-35	-54	-72	-92	-113	-392	-30%
Arizona	-31	-69	-157	-252	-351	-462	-578	-1900	-25%
Arkansas	-158	-219	-317	-419	-516	-621	-733	-2982	-35%
California	460	346	-114	-618	-1248	-1988	-2759	-5921	-17%
Colorado	-3	-32	-91	-152	-215	-297	-383	-1172	-25%
Connecticut	-189	-288	-403	-528	-661	-825	-995	-3889	-41%
Delaware	17	10	-4	-18	-34	-50	-68	-146	-20%
DC	36	-7	-56	-110	-168	-230	-296	-832	-34%
Florida	-456	-703	-1093	-1487	-1861	-2272	-2698	-10570	-34%
Georgia	-258	-405	-648	-891	-1124	-1378	-1642	-6346	-33%
Hawaii	50	23	-8	-41	-73	-109	-147	-305	-28%
Idaho	-27	-37	-58	-81	-104	-129	-154	-590	-28%
Illinois	104	28	-189	-429	-689	-1032	-1392	-3599	-22%
Indiana	-717	-839	-1038	-1250	-1477	-1725	-1992	-9039	-45%
Iowa	-41	-56	-104	-156	-224	-300	-380	-1261	-26%
Kansas	-58	-62	-90	-121	-154	-192	-235	-911	-21%
Kentucky	-257	-340	-488	-648	-810	-990	-1176	-4708	-34%
Louisiana	-1046	-1422	-1831	-2254	-2668	-2969	-3286	-15475	-53%
Maine	-73	-79	-117	-161	-210	-266	-333	-1238	-29%
Maryland	51	14	-101	-227	-357	-501	-653	-1773	-25%
Massachusetts	-23	-251	-514	-805	-1119	-1460	-1817	-5990	-38%
Michigan	-123	-219	-442	-688	-956	-1306	-1673	-5408	-27%
Minnesota	79	68	-30	-142	-268	-406	-550	-1248	-20%
Mississippi	36	-0	-85	-176	-263	-359	-459	-1306	-19%
Missouri	-185	-187	-242	-305	-372	-447	-524	-2261	-20%
Montana	-63	-87	-122	-155	-185	-217	-251	-1079	-38%
Nebraska	-15	-24	-57	-94	-132	-176	-220	-718	-27%
Nevada	-51	-63	-82	-104	-128	-155	-183	-767	-35%
New Hampshire	-94	-120	-150	-182	-209	-237	-268	-1259	-41%
New Jersey	-552	-637	-840	-1061	-1289	-1540	-1801	-7720	-35%
New Mexico	27	3	-44	-92	-139	-191	-246	-682	-21%
New York	531	-457	-1632	-2941	-4364	-5913	-7533	-22311	-34%
North Carolina	-423	-611	-892	-1169	-1420	-1694	-1977	-8187	-36%
North Dakota	-26	-32	-47	-63	-80	-102	-127	-477	-28%
Ohio	-248	-369	-696	-1065	-1455	-1883	-2330	-8047	-30%
Oklahoma	-259	-324	-424	-527	-625	-733	-842	-3734	-40%
Oregon	137	112	52	-18	-89	-168	-250	-224	-15%
Pennsylvania	362	334	57	-251	-577	-938	-1318	-2331	-18%
Rhode Island	-24	-74	-132	-197	-264	-340	-417	-1447	-39%
South Carolina	-201	-245	-340	-438	-527	-626	-728	-3104	-26%
South Dakota	5	2	-11	-27	-43	-60	-79	-213	-18%
Tennessee	-71	-151	-341	-536	-717	-918	-1141	-3875	-25%
Texas	-570	-784	-1200	-1615	-2008	-2543	-3098	-11817	-27%
Utah	-38	-58	-97	-136	-176	-221	-268	-994	-28%
Vermont	22	5	-15	-37	-62	-88	-116	-290	-30%
Virginia	-168	-239	-354	-473	-585	-709	-838	-3367	-33%
Washington	-90	-273	-477	-687	-902	-1134	-1378	-4940	-42%
West Virgina	-267	-360	-499	-638	-775	-938	-1109	-4586	-43%
Wisconsin	-92	-140	-250	-372	-502	-672	-850	-2878	-27%
Wyoming	-6	-10	-19	-29	-38	-48	-58	-208	-26%

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SOURCES: Urban Institute March Baseline, normalized to equal CBO's March baseline for DSH and non-DSH costs. GAO estimate of grants by state by year under the proposed block grant / aggregate cap.

HOUSE COMMERCE MARK

Estimated Reduction in Federal Medicaid Spending

relative to CBO's projection of current law. In millions of dollars

	1996	1997	1998	1999	2000	2001	2002	7-yr Tot	Percent cut in 2002
Total	-3770	-8054	-16014	-24542	-33410	-43343	-53743	-182876	-30%
Alabama	-20	-20	-86	-156	-223	-298	-376	-1180	-15%
Alaska	-9	-33	-53	-79	-102	-129	-156	-560	-42%
Arizona	110	92	11	-78	-171	-279	-396	-711	-17%
Arkansas	-170	-227	-328	-432	-532	-641	-757	-3086	-36%
California	-251	-376	-831	-1326	-1944	-2667	-3418	-10813	-21%
Colorado	-80	-114	-179	-247	-319	-403	-486	-1827	-32%
Connecticut	-2	-96	-208	-331	-457	-618	-784	-2496	-32%
Delaware	-5	-21	-41	-61	-83	-107	-132	-449	-40%
DC	5	-38	-89	-141	-202	-265	-331	-1062	-38%
Florida	-696	-944	-1330	-1717	-2085	-2485	-2900	-12157	-36%
Georgia	-172	-298	-575	-858	-1133	-1434	-1750	-6220	-35%
Hawaii	-3	-12	-38	-65	-91	-121	-152	-482	-29%
Idaho	-30	-42	-60	-81	-93	-125	-149	-580	-27%
Illinois	-235	-322	-590	-908	-1236	-1596	-1948	-6835	-31%
Indiana	-314	-522	-779	-1056	-1352	-1673	-2010	-7707	-46%
Iowa	-9	-17	-77	-142	-211	-288	-370	-1114	-25%
Kansas	30	37	2	-36	-77	-123	-176	-342	-16%
Kentucky	-264	-339	-490	-653	-820	-1003	-1194	-4762	-35%
Louisiana	-56	-137	-426	-732	-1022	-1340	-1678	-5390	-27%
Maine	5	-39	-91	-149	-214	-287	-372	-1146	-32%
Maryland	-17	-79	-216	-365	-519	-690	-870	-2755	-34%
Massachusetts	167	-57	-316	-604	-913	-1250	-1603	-4577	-33%
Michigan	6	-60	-330	-629	-954	-1313	-1689	-4970	-27%
Minnesota	89	3	-137	-291	-463	-650	-846	-2294	-31%
Mississippi	-64	-101	-186	-276	-361	-454	-552	-1994	-23%
Missouri	147	184	118	43	-38	-130	-224	101	-8%
Montana	-54	-76	-115	-153	-186	-226	-262	-1071	-40%
Nebraska	-8	-35	-79	-127	-178	-235	-294	-956	-36%
Nevada	-36	-44	-62	-81	-102	-126	-148	-600	-28%
New Hampshire	106	91	72	52	29	6	-20	337	-3%
New Jersey	-275	-503	-763	-1045	-1340	-1659	-1994	-7579	-39%
New Mexico	-16	-40	-86	-134	-180	-230	-283	-969	-24%
New York	108	-887	-2072	-3389	-4821	-6379	-8008	-25450	-36%
North Carolina	-385	-555	-874	-1194	-1491	-1815	-2153	-8468	-40%
North Dakota	-17	-21	-40	-60	-81	-104	-129	-452	-29%
Ohio	-393	-504	-859	-1243	-1650	-2096	-2562	-9308	-33%
Oklahoma	-251	-310	-405	-502	-594	-694	-794	-3550	-37%
Oregon	-65	-92	-168	-241	-324	-411	-495	-1796	-29%
Pennsylvania	484	348	14	-354	-746	-1176	-1631	-3061	-23%
Rhode Island	-92	-142	-202	-269	-337	-416	-493	-1950	-46%
South Carolina	-32	-53	-140	-230	-313	-404	-497	-1668	-18%
South Dakota	-4	-7	-24	-47	-69	-90	-115	-356	-26%
Tennessee	-341	-431	-642	-858	-1062	-1285	-1520	-6139	-33%
Texas	-36	-170	-520	-862	-1178	-1653	-2211	-6629	-20%
Utah	-46	-64	-104	-145	-187	-233	-282	-1061	-30%
Vermont	-5	-23	-43	-66	-91	-118	-146	-491	-38%
Virginia	-194	-261	-372	-486	-616	-761	-900	-3591	-36%
Washington	-71	-253	-458	-667	-881	-1113	-1356	-4798	-41%
West Virgina	-225	-308	-464	-619	-770	-936	-1110	-4432	-43%
Wisconsin	-90	-129	-265	-417	-579	-756	-942	-3178	-30%
Wyoming	4	-7	-20	-35	-49	-64	-80	-251	-35%

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SOURCES: Urban Institute March Baseline, normalized to equal CBO's March baseline for DSH and non-DSH costs. GAO estimate of grants by state by year under the proposed block grant / aggregate cap.

SENATE FINANCE vs HOUSE COMMERCE

Senate +/- House. A "minus" means that the Senate cuts deeper.
In millions of dollars

	1996	1997	1998	1999	2000	2001	2002	7-yr Tot	FY 2002 percentage point cut
Total	-1414	-1506	-1138	-743	-313	169	672	-4273	0%
Alabama	-171	-194	-201	-209	-216	-226	-234	-1451	-9%
Alaska	0	15	18	25	30	37	43	168	11%
Arizona	-141	-161	-168	-174	-180	-183	-182	-1189	-8%
Arkansas	12	8	11	13	16	20	24	104	1%
California	711	722	717	708	696	679	659	4892	4%
Colorado	77	82	88	95	104	106	103	655	7%
Connecticut	-187	-192	-195	-197	-204	-207	-211	-1393	-9%
Delaware	22	31	37	43	49	57	64	303	19%
DC	31	31	33	31	34	35	35	230	4%
Florida	240	241	237	230	224	213	202	1587	3%
Georgia	-86	-107	-73	-33	9	56	108	-126	2%
Hawaii	53	35	30	24	18	12	5	177	1%
Idaho	3	5	2	0	-11	-4	-5	-10	-1%
Illinois	339	350	401	479	547	564	556	3236	9%
Indiana	-403	-317	-259	-194	-125	-52	18	-1332	0%
Iowa	-32	-39	-27	-14	-13	-12	-10	-147	-1%
Kansas	-88	-99	-92	-85	-77	-69	-59	-569	-5%
Kentucky	7	-1	2	5	10	13	18	54	1%
Louisiana	-990	-1285	-1405	-1522	-1646	-1629	-1608	-10085	-26%
Maine	-78	-40	-26	-12	4	21	39	-92	3%
Maryland	68	93	115	138	162	189	217	982	8%
Massachusetts	-190	-194	-198	-201	-206	-210	-214	-1413	-4%
Michigan	-129	-159	-112	-59	-2	7	16	-438	0%
Minnesota	-10	65	107	149	195	244	296	1046	11%
Mississippi	100	101	101	100	98	95	93	688	4%
Missouri	-332	-371	-360	-348	-334	-317	-300	-2362	-11%
Montana	-9	-11	-7	-2	1	9	11	-8	2%
Nebraska	-7	11	22	33	46	59	74	238	9%
Nevada	-15	-19	-20	-23	-26	-29	-35	-167	-7%
New Hampshire	-200	-211	-222	-234	-238	-243	-248	-1598	-38%
New Jersey	-277	-134	-77	-16	51	119	193	-141	4%
New Mexico	43	43	42	42	41	39	37	287	3%
New York	423	430	440	448	457	466	475	3139	2%
North Carolina	-38	-56	-18	25	71	121	176	281	3%
North Dakota	-9	-11	-7	-3	1	2	2	-25	0%
Ohio	145	135	163	178	195	213	232	1261	3%
Oklahoma	-8	-14	-19	-25	-31	-39	-48	-184	-2%
Oregon	202	204	220	223	235	243	245	1572	14%
Pennsylvania	-122	-14	43	103	169	238	313	730	4%
Rhode Island	68	68	70	72	73	76	76	503	7%
South Carolina	-169	-192	-200	-208	-214	-222	-231	-1436	-8%
South Dakota	9	9	13	20	26	30	36	143	8%
Tennessee	270	280	301	322	345	367	379	2264	8%
Texas	-534	-614	-680	-753	-830	-890	-887	-5188	-8%
Utah	8	6	7	9	11	12	14	67	1%
Vermont	27	28	28	29	29	30	30	201	8%
Virginia	26	22	18	13	31	52	62	224	2%
Washington	-19	-20	-19	-20	-21	-21	-22	-142	-1%
West Virgina	-42	-52	-35	-19	-5	-2	1	-154	0%
Wisconsin	-2	-11	15	45	77	84	92	300	3%
Wyoming	-10	-3	1	6	11	16	22	43	10%

Center on Budget and Policy Priorities
September 29, 1995

SOURCES: Urban Institute March Baseline, normalized to equal CBO's March baseline for DSH and non-DSH costs.
GAO estimate of grants by state by year under the proposed block grant / aggregate cap.

Block Grants Impact on Children

- The Republican proposal eliminates protections for families and spouses of nursing home residents.
- Families could be forced to divert savings for their children's needs such as education and health care to pay the nursing home costs of their elderly parents - which average $38,000 per year.
- The proposed Medicaid block grant coupled with the $182 billion budget cut for Medicaid will force states to reduce coverage.
- Low income children, who comprise 49% of Medicaid beneficiaries, will suffer the most if states reduce Medicaid coverage.
- The Urban Institute estimates that over 4.4 million children will lose Medicaid coverage under the Republican proposal by year 2000.
- This figure may actually be even higher if the powerful lobbyists for the elderly and the nursing home industry do their jobs correctly and protect the interests of their clients.
- Children - particularly low-income children, don't have powerful, high-paid lobbyists. There is no one to represent their interests in this Republican legislative process - that is why they are vulnerable under the Republican proposal.
- The Republican proposal requires states to spend minimal amounts of their funds on low income families. This amount is only 40 percent of what states are currently spending on mandatory services - essential services such as hospital services, physician services, and x-rays.
- This means children will also lose access to essential primary and preventive care services - such as eye exams and hearing tests.
- Of all Medicaid children, the most vulnerable under the Republican proposal are children with disabilities - children with cerebral palsy, spina bifida, AIDS and other life-long debilitating diseases.
- Medicaid is the primary source of payment for medical services for children with disabilities.
- Medicaid covers 90 percent of all children with HIV and AIDS.

- These children and their families stand the most to lose under the Republican proposal. Their conditions demand intensive health care services - usually the most expensive to provide.

- As states are forced to provide medical care under a fixed block grant, coverage for the most expensive beneficiaries and services will be reduced.

David

- David is eight years old and was a healthy child until he contracted viral encephalitis in 1991. He is now blind; has a severe seizure disorder; and is medically fragile.
- David lost his insurance when his father's company was sold - the insurance plan offered through his father's new employer will not cover David.
- Due to his high medical expenses and severe disability, David qualifies for Medicaid.
- Under the Republican proposal, David is not guaranteed Medicaid coverage.
- He may be denied access to Medicaid - just like he was denied access to private health insurance.
- David's mom may be forced to quit her job - adding to the family's economic burden - in order to provide David the care he needs.

Edna

- Edna is 76 years old. Her husband, Wilson, served in the Navy and then worked for 23 years as a science teacher, while supplementing his income by working every evening at a supermarket.
- Edna and Wilson lived on his pensions and their Social Security benefits after Wilson retired in the late 70's.
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- With the help of Medicaid, Edna is able to ensure that Wilson gets the care he needs, and retain a modest monthly income of $1,230 for her living expenses.
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The Medicaid Program and EPSDT

- The Medicaid program, authorized by title XIX of the Social Security Act, is a Federal-State matching entitlement program that provides medical assistance for certain individuals and families with low incomes and resources.

- Medicaid is the largest program providing medical and health-related services to America's poorest people.

- Adolescents enrolled in Medicaid are entitled to a comprehensive range of preventive, primary, and specialty services encompassed within the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- The Early Periodic Screening Diagnosis and Treatment Program (or EPSDT) has been part of the Medicaid program for over 20 years.

- The purpose of the program is to identify children with health problems and ensure the problems are appropriately diagnosed and treated.

- EPSDT is the preventive child health component of the Medicaid program.

- States must provide all medically necessary services, including age-appropriate screening and anticipatory guidance, to all Medicaid-eligible children.

- States may set their own periodicity schedules; the standards of the American Academy of Pediatrics are commonly utilized for this purpose.

- EPSDT is a comprehensive health program for Medicaid-eligible individuals under age 21.

- During fiscal year 1995, States will be expected to meet or exceed goals of 80 percent for EPSDT participation and screening for all age groups.

- In FY 1993 16.3 million children under the age of 21 received services under Medicaid. They represented 48.7% of the total Medicaid population served.

- In FY 1993, $16.5 billion was spent on Medicaid services for children under age 21. However, this only represented 16.2 percent of total Medicaid expenditures.

- The Republicans in Congress want to eliminate the Medicaid as an entitlement and create a block grant.

- Under these block grants, States would have full discretion to decide who would be eligible for Medicaid services and what type of services they would receive.

- There would no longer be mandatory coverage of any specific population -- including low-income children.

- Nor would there be mandatory provision of certain services, such as preventive services like vision and hearing screenings for infants and toddlers.

- This block grant coupled with the proposed budget cut of $182 billion (a reduction in Medicaid payments by 30% in 2002) will force states to reduce the number of people receiving Medicaid services.

- The Urban Institute estimates that over 8.8 million people will lose Medicaid coverage in 2002.

- 4.4 million of these individuals will be children.

Medicaid Background

- Medicaid plays an enormous role in health care coverage.
- It provided health care to between one-third and one-half of all babies under 1 year old and 33.9 percent of children ages 1 to 5.
- The HCFA Actuary estimates that Medicaid paid for about one-third of all births in the United States during 1993.
- The Medicaid program appears to be a significant and growing source of health insurance for increasing numbers of low-income eligibles.
- According to a recently released Kaiser Commission report, Medicaid coverage increased from 9 percent of the population in 1989 to over 14 percent in 1994. During this period, the rate of coverage through private, employer-sponsored plans dropped significantly (from 66 percent to 59 percent) but, with the rate of coverage through the Medicaid program increasing considerably, the percentage of uninsured remained constant at 16 percent. Composition of who is uninsured has changed.
- Another important characteristic of Medicaid to remember is that though fewer Medicaid recipients are elderly and disabled, services provided to these two groups cost substantially more, on average, than those provided to children and other adults.
- The elderly and disabled comprised only 27 percent of enrollment but accounted for 67 percent of Medicaid in fiscal year 1993.
- Children, adults who care for them, and pregnant women comprised 73 percent of Medicaid enrollees but accounted for only 33 percent of spending during that year.
- While many believe that Medicaid program spending is out of control (based on annual increases of almost 30 percent each year between 1990 and 1992), [caused substantially by uncontrolled DSH expenditures and donations and taxes State revenue sources,] current spending trends indicate that the inflated rate of growth of this period has come to a close.
- Medicaid benefit outlays grew less than 9 percent in 1994 and are projected to grow at roughly 8 percent for 1995.

MEDICAID BACKGROUND

OVERVIEW

- Medicaid covers over 36 million Americans
- Medicaid provides three types of critical health protection:
  - Health insurance for low-income families and people with disabilities.
  - Long-term care for older Americans and people with disabilities.
  - Medigap coverage that helps low-income elderly fill in the gaps of the limited Medicare benefit.

STATE AND FEDERAL PARTNERSHIP

- In 1995, Medicaid will spend approximately $156 billion: states will pay an estimated $67 billion and the federal government will pay $89 billion.
- States administer Medicaid under broad federal guidelines, and receive federal matching payments related to each state's per capita income.

MEDICAID COVERAGE AND SPENDING

- Only 27 percent of the people enrolled in Medicaid are elderly and disabled, but they account for 69 percent of the spending.
- Conversely, while 71 percent of the people on Medicaid are children and their families, they account for only 29 percent of the spending.

MEDICAID SPENDING GROWTH

- CBO projects that aggregate Medicaid spending will grow at an average rate of 10.2 percent between 1996 and 2002.
  - This is lower than growth of expenditures in the early 1990s, when the average rate was closer to 20 percent.
- Medicaid spending growth results from three different pressures: increases in the price of health care, utilization and intensity of health care, and the number

of people covered.

- The Kaiser Foundation estimates that approximately one third of the growth in Medicaid expenditures from 1988-1993 is attributed to enrollment, one third to general medical inflation, and one third to utilization increases and provider payment changes, including DSH.

Background:

Enrollment	-- 34.1 percent
Medical inflation	-- 31 percent
Utilization (including DSH)	-- 28.4 percent
Increase in Medicare premiums	-- 2.9 percent
Increase in HMO premiums	-- 3.6 percent

ENROLLMENT GROWTH DRIVES MEDICAID SPENDING GROWTH

- Medicaid growth is largely driven by enrollment growth, especially among the elderly and disabled. According to CBO, about 45 percent of the total spending increases results from a rising number of people in the program.

- Medicaid enrollment growth reflects the fact that the population is aging. The number of aged and disabled beneficiaries is growing at 4.6 percent per year -- almost twice the rate for adults and children, whose projected average growth rate is 2.4 percent.

MEDICAID SPENDING GROWTH PER PERSON IS LOW

- Medicaid spending per beneficiary is projected to grow at 7 percent per year between 1996 and 2002.

- This growth rate is the <u>same</u> as the projection of the private health insurance spending per insured person under the CBO baseline.

- Historically, Medicaid spending per beneficiary has been below private insurance spending per insured person.

THE REPUBLICAN BUDGET RESOLUTION: UNPRECEDENTED CUTS

- The Republican Budget Resolution would cut Medicaid by 20 percent -- $182 billion over the next 7 years.

- The Republicans would achieve these savings by imposing an annual growth rate cap on aggregate spending - that is less than enrollment growth plus inflation.

- Taking enrollment growth into account, the Republican Budget would limit growth in Medicaid spending per person

to only 1.4 percent annually.

A CRITICAL SAFETY NET

- Medicaid coverage is especially important since employer coverage has been declining. Between 1988 and 1994:
  - The percentage of Americans covered by employer-sponsored health insurance fell from 67 percent to about 61 percent.
  - Medicaid coverage increased from 9 to 13 percent.
- If Medicaid coverage had not increased, there would be more uninsured, more uncompensated care, and more cost-shifting.

CHART 1: STATE LOSSES UNDER REPUBLICAN MEDICAID BLOCK GRANT

- Republican cuts of $182 billion over 7 years in Medicaid mean states will lose significant federal financial assistance, both in absolute dollars and as a percentage of current dollars.
- Losses of this magnitude cannot be absorbed through "efficiencies" or through reductions in provider payments.
- 49 states will lose over 20 percent of their projected federal Medicaid payments.
- 9 states will lose a third or more of their projected federal Medicaid payments.

CHART 2: MILLIONS OF AMERICANS LOSE HEALTH COVERAGE UNDER MEDICAID BLOCK GRANT

- Republican cuts of $182 billion over 7 years will force states to reduce coverage.
- According to the Urban Institute, in the year 2002 alone, 8.8 million Americans would lose their Medicaid insurance coverage.
- Half of them would be children.
- These are very conservative estimates. They assume states could absorb half of the $182 billion cut by reducing their per recipient spending growth rate to inflation plus 1.9 percent.

However, the Republican conference agreement assumes a per recipient growth rate of less than inflation. Therefore, coverage losses among children, working families, and the elderly and disabled requiring long-term care are likely to be much higher.

CHART 3: BLOCK GRANT BASED ON CURRENT MEDICAID PAYMENTS IS INEQUITABLE

- There is considerable variation in federal Medicaid grants to states - from a high of $10.7 billion to New York to a low of $100 million to Wyoming.

- On a per recipient basis, the variation also is dramatic. In fiscal 1994 the federal government paid New Hampshire over $5,400 per Medicaid recipient while Virginia received slightly more than $1,400 per recipient.

- In a matching grant program, such variation is understandable. The amount of federal assistance depends on the amount of state effort, changes in state economic conditions, and other factors.

- Under a block grant, however, states would be locked into the level of federal assistance they receive today, regardless of how their circumstances might change.

CHARTS 4 & 5: TIGHT MEDICAID SPENDING GROWTH CAPS ARE WILL HURT STATES

- The rate of Medicaid spending growth varies widely from state to state.

- From 1988-1993, Medicaid spending in "high growth" states grew more than three times faster than in "low growth" states.

- The largest single factor driving Medicaid spending growth in enrollment growth.

- Medicaid spending growth rates tend to vary over time. For example, Medicaid spending growth in a state can increase during an economic downturn, then slow as the state economy improves (Chart 5).

- In order to achieve $182 billion in savings, the Republican conference agreement will cap total Medicaid spending growth to an average of 4.5 percent -- less than half of the projected spending growth rate of 10.2 percent projected for the period 1996-2002.

- Such tight growth caps are unrealistic and unfair. No

state can meet such targets, and those states experiencing periods of high Medicaid cost growth (for example, during recessions) will be particularly hard hit.

MODIFYING STATE SPECIFIC GROWTH RATES WON'T WORK

- Republicans are expected to use differential growth rates to try to ameliorate the unfairness of their block grants. It won't work.

- As they tried on welfare reform, Republicans will try to win votes by applying higher growth rate caps to those states who currently receive less federal assistance, while applying lower growth rate caps to those states currently receiving more federal assistance.

- However, no change in growth rates can make up for the magnitude of cuts states will experience under the Republican plans for Medicaid. Applying the Dole welfare reform formula to the Medicaid program illustrates why:

  - For example, New York today receive almost $3,700 in federal matching dollars per Medicaid recipient while Texas receive less than $2,100. The Dole welfare reform formula would try to reduce this disparity over time by permitting Medicaid spending to grow at a faster rate in Texas than in New York.

  - However, after cutting $182 billion, Republicans won't have left enough growth in Medicaid to cushion state losses.

  - As the chart shows, while Texas' gain (a loss of $11 billion pared down to $10 billion) would be New York's loss (a loss of $18 billion increased to $19 billion) under the Dole welfare reform formula, neither state can afford to absorb such huge cuts in federal funding.

VACCINES FOR CHILDREN PROGRAM

- Immunization represents one of the most, if not the most, cost effective public health intervention.
- However, in 1994 about 600,000 to 2 million of our nation's children between 19 and 35 months of age did not receive recommended vaccines against specific diseases.
- On October 1, 1994, HHS implemented the Vaccines for Children (VFC) program.
- The VFC program provides free vaccine to children at participating public and private health-care provider sites.
- Children who are eligible for free vaccines include those on Medicaid, those without insurance, and American Indians/Alaskan Natives.
- In addition, children whose insurance does not cover vaccinations (i.e., who are under-insured) can receive vaccine through the VFC at Federally Qualified Health Centers and Rural Health Clinics.
- Other children can receive free vaccine at public clinics (and in some States, from private providers) under programs other than VFC.
- The Vaccines for Children is designed to reduce cost as a barrier to immunization.
- Furthermore, the VFC program allows children to obtain immunization in their medical home where they can receive other components of care that promote their health at the same visit, such as counseling about prevention of poisioning and injuries.
- The Republicans in Congress want to eliminate VFC.

Children Talking Points

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- **9 states will lose a third or more of their projected federal Medicaid payments.**

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