Opinion

Federal Dollars and State Flexibility: The Debate Over Medicaid's Future

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for one in eight Americans. Although less central than Medicare to the political debate in 1965 and again in 1995, Medicaid nonetheless plays a major role as a health insurer and safety net for vulnerable Americans throughout the health care system.

Today, Medicaid finances care for one in four American children, pays for one-third of the nation's births, assists 60% of people living in poverty, pays for half of all nursing home care for frail elderly and disabled Americans, and accounts for 13% of all U.S. health care spending (Holahan, Winterbottom, and Rajan 1995; Levit et al. 1994). It is the source of insurance for 13% of the nonelderly population and supplements Medicare by paying premiums and cost sharing for one in 10 elderly and disabled Medicare beneficiaries (EBRI 1995). Its funding is the major source of federal financial assistance to the states, accounting for 40% of all federal grant-in-aid payments to states (National Association of State Budget Officers 1994).

As it enters its 30th year, Medicaid is at a critical juncture. At a cost of $158 billion to federal and state governments in 1995, Medicaid is both the mainstay of financing for health insurance and long-term care for 37 million low-income and aged and disabled Americans, and a substantial and growing federal and state budgetary commitment (Holahan and Liska 1995a). The rising cost of maintaining the Medicaid safety net underlies a growing tension in the federal and state partnership for Medicaid and the debate over new approaches for the future. Beyond the structures and formulas of intergovernmental relationships, however, lies a program that finances America's most complicated and intractable health care concerns.

In recent years, Medicaid has been viewed at the federal level as a vehicle to broaden coverage for low-income children, pregnant women, and elderly and disabled Americans, but also as a source of escalating federal spending as states adopt new financing strategies to maximize federal funding. From a state perspective, the program has provided federal assistance in financing indigent care, but also has imposed federal requirements and rules concerning the expenditure of federal funds, limiting states' flexibility in managing their programs. The tension in federal and state relations has been sharpened by the growing pressure to restrain spending at both levels of government.

With Congress struggling to balance the federal budget, Medicaid is now at the center of a fiscal and philosophical tug-of-war between the federal and state governments over how responsibility is divided over program structure and costs. The philosophical debate is whether Medicaid will continue as an entitlement program with federal funds matching
state expenditures for eligible populations and services or be converted to a block grant that caps federal funding and gives full flexibility to states to shape and run their programs. The fiscal battle that emerged during the summer of 1995 centered on how to limit federal dollars and allocate these dollars across states.

The complexity of the existing program, the multiple and diverse populations it serves, the maldistribution of health resources that compromises access to care for the poor, and the limitations on what can be achieved through savings before eligibility and benefits must be cut confound the fiscal and philosophical issues. How these issues are resolved is at the heart of the debate and will determine how we as a nation provide health and long-term care services to poor, sick, old, and disabled Americans.

What Is Medicaid?

Authorized under Title XIX of the Social Security Act in 1965, Medicaid is a means-tested entitlement program that is jointly financed by the federal and state governments. States elect to participate in Medicaid and federal requirements and state choices determine Medicaid's structure. The federal government matches from 50% to 79% of program expenditures, depending on the state's per capita income.

States design and operate the program within federal guidelines that determine the population groups and services for which the federal government will match state expenditures. Because states make different decisions about whom to cover, what benefits to provide, and what to pay for services, the scope and cost of the program vary widely across states. As a result, Medicaid is multiple programs, configured and operated somewhat differently in each of the 50 states and the District of Columbia.

For 16 million children and seven million adults in low-income families, Medicaid is a health insurance program with comprehensive benefits and little or no cost sharing. For nearly four million low-income elderly people and five million low-income people with disabilities, Medicaid has several roles (Kaiser Commission on the Future of Medicaid 1995a). It is a long-term care program for home- and community-based services and the dominant source of public financing for nursing home care. In addition, Medicaid is a supplementary insurance program to Medicare, paying Medicare's premiums and cost-sharing requirements and covering additional services, most notably prescription drugs and long-term care for low-income Medicare beneficiaries. For low-income disabled adults who do not have Medicare coverage, Medicaid also serves as a health insurance program.

Low-income children and their parents make up the majority of Medicaid beneficiaries, but the elderly and disabled account for the majority of Medicaid spending. Three-quarters of Medicaid beneficiaries are adults and children in low-income families, but they account for only 27% of spending. In contrast, the elderly and disabled account for 27% of beneficiaries and 59% of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings (Kaiser Commission on the Future of Medicaid 1995a). In addition, 14% of spending is for disproportionate share hospital payments intended to assist hospitals with large proportions of low-income and uninsured patients (Kaiser Commission on the Future of Medicaid 1995b).

Elderly beneficiaries rely on Medicaid mostly for long-term care financing, while the disabled are heavy users of both acute and long-term care. Because aged and disabled beneficiaries use more (and more expensive) services, the cost to cover them is substantially higher than is the cost for children and adults in low-income families. The average per beneficiary Medicaid cost in 1993 was $1,191 per child and $2,067 per non-aged adult compared to $7,956 per disabled beneficiary and $9,293 per elderly beneficiary (Kaiser Commission on the Future of Medicaid 1995c). With an almost eightfold difference between the cost of a child and an elderly beneficiary, the cost of any state's Medicaid program is
determined largely by the mix of beneficiaries covered by the program.

Medicaid is thus an expensive program because it provides health insurance coverage and long-term care financing for many of the nation's poorest and most disabled individuals. It is a safety net for individuals with the most catastrophic of illnesses—chronic illnesses for children that leave them disabled for a lifetime, mental illness and retardation that require intensive care in the community or an institutional setting, and long-term nursing home care for the aged and disabled. Medicaid's average cost for a pregnant woman or child without complex medical needs is often substantially lower than a comparable private insurance premium, whereas the average cost for a severely retarded individual on Medicaid can exceed $50,000 per year, an expense not covered by most private insurance plans.

In filling these roles, Medicaid has become a major budgetary commitment for both the federal and state governments. Medicaid expenditures have escalated rapidly in recent years, growing from $51 billion in 1988 to $158 billion in 1995 (Kaiser Commission on the Future of Medicaid 1995a; Holahan and Liska 1995a). The federal share, roughly 56% of total expenditures, is projected to grow from $89 billion in 1995 to $178 billion in 2002 (Antos 1995). Federal expenditures for Medicaid now account for 6% of the federal budget while state Medicaid funds account for an average 20% of all state spending (Checkett 1995).

Although historical rates of growth for Medicaid have been more moderate than increases in private health care spending, Medicaid costs rapidly accelerated in the late 1980s, with annual rates of increase in excess of 25% between 1990 and 1992 (Kaiser Commission on the Future of Medicaid 1995d). The excessive growth rates during this period were attributable to several factors, including a national recession and growth in the number of people eligible for Medicaid, inflation in health care spending, and states' use of statutory loopholes to leverage additional federal dollars. Legislative changes in 1991 curtailed the major alternative financing methods used by states to generate more federal matching funds and the growth rate for Medicaid has now returned to historical levels of about 10% per year (Antos 1995).

What Does a Block Grant for Medicaid Mean?

The rapid escalation in Medicaid spending over the last decade, combined with growing pressure to restrain government spending, has made Medicaid a major factor in the Congressional debate over balancing the federal budget. The June 1995 Joint Budget Resolution recommends restraining federal spending on Medicaid in order to achieve savings of $182 billion over the next seven years; this has set the stage for a major re-examination of the program. The joint federal-state responsibility for the organization and financing of the program and the manner in which care for the poor is provided are on the table.

The Medicaid program's current status as an entitlement for low-income, elderly, and disabled Americans, and as an entitlement to states for federal matching funds for individuals and services that fall within federal guidelines, provides a safety net for both states and their low-income residents. The matching funds provided by the federal government through Medicaid enable states to respond to changes in the economy that affect the number of poor and uninsured in each state, to accommodate population growth, and to undertake health and long-term care reform at the state level. The matching funds also allow states to make different choices regarding whom is covered, what is covered, and how providers are paid. As a result, Medicaid varies in scope of coverage and level of expenditures across states.

For the states, this structure provides flexibility, but also brings with it federal requirements on how and whom those funds can be spent. For the federal government, this structure provides a federal framework establishing a floor for health and long-term care coverage across the states, but
leaves the level and growth of federal spending to be driven by the actions of individual states.

Today's debate reflects the growing tension over how to control spending and divide policy and fiscal responsibility between the federal government and the states. If Congress curbs federal Medicaid spending by limiting the federal dollars available to finance Medicaid in the states to a set percentage increase each year over current spending, the states argue that they would need broad control over program eligibility, benefits, provider payment, and delivery systems to accommodate the restriction on federal funds.

To provide the states with the flexibility to redesign their Medicaid programs in response to the federal funding limits, proposals are being discussed that would replace the current entitlement program with a block grant to the states. Instead of guaranteeing insurance coverage, protection for nursing home residents, and federal financing for all individuals who meet Medicaid's eligibility criteria, a block grant would provide states with federal funds and the discretion to decide how those funds could be used.

Under a block grant, states would gain control over the scope and design of the program, but lose unrestricted federal matching payments, which would be capped. If the formula for distribution of future federal dollars is based on their current allocation to states, the expenditure reductions would be distributed unevenly across states. In general, states that historically have spent more on Medicaid (such as New York, Connecticut, and Massachusetts) would receive smaller percentage reductions in federal payments; states that historically have spent less on Medicaid (such as Florida, New Mexico, and West Virginia) would have higher percentage reductions (Kaiser Commission on the Future of Medicaid 1995; Holahan and Liska 1995b).

This means some states would have a harder time meeting the needs of the low-income population because they would be starting from a more limited base than other states. States experiencing increases in their low-income population, such as Florida or Texas, also are disadvantaged by a historically based formula. Assuming a fixed amount of federal funds, adjusting the formula to assist high population growth states that traditionally have had more limited programs would result in deeper reductions for states that have provided more comprehensive coverage and benefits in the past, such as New York or Massachusetts. Changing the allocation formula for a fixed amount of federal funds means that if one state gets more money, another state has to get less.

The reductions in federal spending alone would bring about significant change in most states, but the shift from an entitlement to a block grant would dramatically change Medicaid from a program with broad federal guidelines and state options to one that is basically individually configured in each state and operates with a fixed pot of federal money. The amount of flexibility provided to the states under a block grant depends on how Congress sets up the program and what strings are attached to the use of federal funds. In the most unrestricted block grant, states would have full discretion over whom is covered, what services are provided, and how providers are paid without requirements for state matching funds or maintenance of effort. It is presumed, however, that states would be required to spend the federal dollars for care to the poor and would be accountable to the federal government with respect to how these funds were spent.

The reduction in federal Medicaid spending coupled with the proposed end to the entitlement nature of Medicaid undoubtedly will result in significant changes in the scope of coverage of the poor, elderly, and disabled, and the way in which their care is organized and financed. The level of the proposed reduction in federal funds in the Joint Budget Resolution—an 18% decrease in federal spending from 1995–2002—is deep and will severely constrain the ability of most states to meet the demands placed on them by growing poor, elderly, and uninsured populations.
Many states have sought a shift to managed care as a means of controlling costs for the Medicaid population by setting a fixed payment per enrollee and putting the health plan at risk for delivering needed services. By moving to managed care, the states hope to make coverage costs more predictable and achieve savings to reduce the growth in program spending and stretch coverage dollars further.

Managed care is not, however, an instant solution to Medicaid’s access and cost concerns. As a public program, Medicaid operates under budget constraints that often have resulted in substandard payment rates. In a capped managed care arrangement where the incentive is to keep utilization low, substandard payment rates could discourage participation by mainstream plans and compromise quality and access. Moreover, significant savings for the overall Medicaid program cannot be achieved if enrollment in managed care focuses only on low-income families, which represent less than one-quarter of Medicaid spending. Even if managed care is able to save 5% to 15% over fee-for-service, as reported in the literature, these savings on care for low-income families would cut overall Medicaid spending by only 1% to 2%.

In considering the options for restructuring this program and reducing the level of federal dollars committed to it, protection for low-income individuals needs to be balanced against fiscal control and state flexibility. The impact of a block grant is highly dependent on the formula by which the federal funds are allocated to the states, the extent to which states are required to match federal funding, the degree of flexibility given to individual states over the use of funds, and ultimately on the decisions made by individual states about how they use the federal dollars. By capping federal contributions and eliminating the individual entitlement to coverage, a block grant leaves both states and their low-income residents vulnerable in times of economic downturn or growth in the poverty population.

What Are the Implications for Medicaid and Its Beneficiaries?

There are no simple solutions to reducing the cost of providing care to the 37 million Americans who now rely on Medicaid or the millions more who fall just beyond its reach. There are just hard choices. Changes in this program will affect the poor, the old, the disabled, and the children who currently are protected by its safety net.

While the states have argued that with greater flexibility they can run their programs to do more while spending fewer dollars, the details underneath the sweeping term “flexibility” are likely to entail limits on eligibility and benefits, cuts in provider payment, and the imposition of cost sharing and premiums for the poor. There is no magic or painless solution—no magic wand of flexibility that can provide medical care and long-term care to one in eight Americans at a dramatically lower cost. Broadened use of managed care will require time to implement, and even then will not accomplish big overall savings for Medicaid unless extended to the elderly and disabled populations, both groups with limited managed care experience.

Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a daunting task. A federally capped block grant for Medicaid is not a solution to maintaining Medicaid’s safety net responsibilities; it is merely a shift of the hard choices and responsibilities from the federal government to the states. In other words, it passes the buck without the bucks.

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health delivery and community-based long-term care services, and stood alone as a primary source of financial assistance with nursing home care. Together, the federal government and state governments have much to be proud of in Medicaid’s accomplishments. In addressing the crises of today, let us not undo the progress Medicaid
has made in providing health and long-term care services to tens of millions of low-income, elderly, and disabled Americans.

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