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Restructuring Medicaid Financing: Implications of the NGA Proposal

Prepared by
John Holahan
for
The Kaiser Commission on
Medicaid and the Uninsured

June 2001

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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Introduction

The National Governors Association, under the leadership of Governors Howard Dean of Vermont and Donald Sundquist of Tennessee, has proposed a major restructuring of the Medicaid program. The stated goals of the restructuring are to provide increased financial support for existing state Medicaid programs, ensure basic levels of services for a core population, and give states increased flexibility in choosing whether and how to cover optional populations and optional services. The NGA is also interested in giving states greater incentives to expand coverage to more of the uninsured. The proposal is multi-faceted and is designed to meet the needs of states with different objectives and problems.

To understand the ways in which the NGA proposal would restructure Medicaid, this paper describes the current of the Medicaid program and then assesses the likely impacts of the NGA proposal on coverage and federal and state spending based on 1998 spending projected to 2001. The analysis simulates the fiscal impact based on several alternative scenarios, including no change in the current program, expanded coverage, and a reduction in optional spending. Findings show that the NGA proposal would shift a substantial share of the cost of Medicaid to the federal government, primarily due to enhanced match. States could also expand coverage substantially because of the enhanced match and spend less than they do currently. The increased flexibility sought under the proposal is unlikely to result in substantial savings.

Background on the NGA Proposal

The NGA proposal would restructure Medicaid into three broad categories. Under Category I, states would be required to cover current mandatory populations, would have to provide them the current mandatory benefits and could not impose cost sharing on mandatory services used by these beneficiaries. States would continue to receive the current federal matching rate for these expenditures.

Category II would include optional services for mandatory populations as well as all services for currently optional populations. States could cover fewer people and provide fewer services than they do today but could also expand coverage significantly. They could also choose whether to continue to provide additional optional benefits to currently mandatory populations. For optional populations, states could provide a benefit package that meets federal benchmark standards as in the State Children's Health Insurance Program (S-CHIP) program, or the "actuarial equivalent". States could impose more cost sharing for optional groups, i.e., premiums, deductibles and copays, but these could not exceed 5% of family income. Because the benefit package would be comprehensive (though less than the typical Medicaid package) states would receive an enhanced match, resulting in a 30% reduction in the state share, as in the S-CHIP program. (Because category II is modeled after and closely resembles S-CHIP in many respects, that program could in principle be integrated with whatever is fashioned under Category II).

Under Category III, states could provide more targeted benefits to any group of beneficiaries. They would have complete freedom to define cost sharing responsibilities of beneficiaries. Because benefit packages could potentially be far more limited (there would be no federal

standards), the NGA proposes that states would receive the current federal matching percentage, not the enhanced matching rate. This category would allow states to be innovative in terms of the groups covered, e.g., they could provide catastrophic coverage, various preventive care services or possibly drug benefits for Medicare beneficiaries. Category III could also lead to some displacement of current state spending on say, public health services.

The Current Structure of Medicaid

To understand the ways in which the NGA proposal would restructure Medicaid, it is essential to begin by describing the current structure of the Medicaid program. Medicaid now requires states to cover certain groups of individuals and allows coverage of others on an optional basis. Federal matching funds are available at the same rate for all mandatory and optional eligibility groups and benefits. Regardless of whether individuals are covered on a mandatory or optional basis, there is a certain set of mandatory benefits and another larger set of benefits that states have the option to provide. Figures 1 and 2 summarize the populations eligible for coverage as well as allowable cost sharing, mandatory benefits and optional benefits for each population group.

As a condition of participation in the Medicaid program, states are required under Section 1931 of the Social Security Act to provide coverage to families that have income and resources that would have qualified them for AFDC under the state's welfare plan on July 16, 1996. States must also cover all children below federal minimum income levels—up to 133% of the federal poverty line if under age six, up to 100% of the federal poverty line if between the ages of six and seventeen, and equal to Section 1931 standards for 18 year olds. States must provide coverage to people eligible for Transitional Medical Assistance (TMA), those who take jobs and their increased earnings make them otherwise ineligible for Medicaid. States are also required to cover pregnant women with incomes less than 133% of the federal poverty line as well as disabled and elderly SSI beneficiaries.

For these groups, states are required to provide a certain set of mandatory benefits including hospital inpatient and outpatient care; physician services; laboratory and x-ray services; early periodic screening, diagnosis and treatment (EPSDT) for children; nursing facility care for those age twenty one and above; and home health care for individuals entitled to nursing facility care. States are permitted to cover a range of optional services including prescription drugs, dental care, physical therapy and related services, care in institutions for the mentally retarded, home care and personal care services. States are also required to pay Medicare Part B premiums, and in some cases Medicare cost sharing, for different groups of elderly and disabled. For one of these groups, Qualified Medicare Beneficiaries, states may also provide full Medicaid benefits.

There are a number of optional groups that states may cover if they choose. They may cover children in families with incomes above the federal minimums cited above. They may cover adults in families with incomes above the minimum Section 1931 standards. They may cover disabled individuals above SSI levels, and elderly persons who receive state supplementary payment system payments (payments that states use to supplement federal SSI allowances) and those receiving home and community-based waiver services. States may also cover the working disabled (with incomes above SSI levels), elderly nursing home residents with incomes above

Table 1

Medicaid Expenditures by Beneficiary Group and Type of Service, 1998 United States (expenditures in millions)

		Expenditures				
			Mandatory		Optional	
Beneficiary Group	**Enrollees[1]** (in millions)	**Total**	**Mandatory Services[1,4]**	**Payments to Medicare**	**Prescription Drugs[2]**	**Optional Services[3,5]**
Total (services only)	**40.3**	**$154,354**	**$96,890**	**$4,419**	**$10,172**	**$42,923**
Mandatory Eligibility[6]	28.6	84,116	49,541	n/a	6,221	26,790
Optional Eligibility[7]	11.7	70,238	47,299	n/a	3,951	17,132
Elderly	**4.1**	**$46,148**	**$33,241**	**$2,651**	**$3,298**	**$6,958**
Mandatory Eligibility	1.8	10,956	5,266	n/a	1,340	3,176
Optional Eligibility	2.3	35,192	27,975	n/a	1,958	3,782
Blind and Disabled	**6.9**	**$67,677**	**$31,134**	**$1,768**	**$6,081**	**$28,695**
Mandatory Eligibility	5.4	44,205	21,148	n/a	4,343	17,325
Optional Eligibility	1.5	23,472	9,986	n/a	1,738	11,370
Adults	**8.7**	**$15,999**	**$12,476**	**$0**	**$794**	**$2,728**
Mandatory Eligibility	5.0	9,364	7,153	0	539	1,673
Optional Eligibility	3.7	6,635	5,324	0	255	1,056
Children	**20.6**	**$24,530**	**$19,989**	**$0**	**n/a**	**$4,541**
Mandatory Eligibility	16.4	19,591	15,975	0	n/a	3,617
Optional Eligibility	4.2	4,938	4,014	0	n/a	924

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

Notes: Does not include the U.S. Territories. Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

na = not applicable, payments to Medicaid are mandatory for all beneficiary groups.

See endnotes for Table 1-2

SSI levels, and pregnant women above 133% of the federal poverty line. If states choose to cover any of these groups they must provide the mandatory benefits listed in Figure 1 and may provide any of the optional benefits. States are generally allowed to impose nominal cost sharing on these populations.

Finally, states may cover the medically needy—these are individuals with incomes slightly above the AFDC payment standards or who incur medical expenses that reduce available incomes below established thresholds. For the medically needy, the mandatory benefit package is more limited, but other optional services may be provided and higher levels of premiums and cost sharing are permitted. It is worthy of note that for the medically needy, the most expensive of the optional populations, states have considerably more flexibility in the current program than they do for other groups.

Federal financial assistance is provided to states for coverage of both mandatory and optional eligibility groups and services. Federal matching payments are based on the state's per capita income. The federal share ranges from 50 to 80% of Medicaid expenditures and averaged 57.2% in 1998, when DSH and administrative costs are excluded. The matching rate is the same across all covered groups and services.

Table 2

Medicaid Expenditures by Beneficiary Group and Type of Service, 1998 United States (expenditures in millions)

		Acute Care Services				Long-Term Care Services	
		Mandatory		Optional			
Beneficiary Group	**Enrollees** (in millions)	**Mandatory Services[1]**	**Payments to Medicare**	**Prescription Drugs[2]**	**Optional Services[3]**	**Mandatory Services[4]**	**Optional Services[5]**
Total (services only)	**40.3**	**$60,525**	**$4,419**	**$10,172**	**$14,088**	**$36,315**	**$28,835**
Mandatory Eligibility[6]	28.6	43,059	n/a	6,221	9,863	6,482	15,927
Optional Eligibility[7]	11.7	17,466	n/a	3,951	4,225	29,833	12,907
Elderly	**4.1**	**$4,909**	**$2,651**	**$3,298**	**$2,182**	**$28,332**	**$4,777**
Mandatory Eligibility	1.8	2,454	n/a	1,340	1,056	2,812	2,120
Optional Eligibility	2.3	2,455	n/a	1,958	1,125	25,520	2,657
Blind and Disabled	**6.9**	**$23,435**	**$1,768**	**$6,081**	**$7,127**	**$7,699**	**$21,567**
Mandatory Eligibility	5.4	17,642	n/a	4,343	5,294	3,506	12,030
Optional Eligibility	1.5	5,793	n/a	1,738	1,833	4,193	9,537
Adults	**8.7**	**$12,312**	**$0**	**$794**	**$2,297**	**$164**	**$431**
Mandatory Eligibility	5.0	7,077	0	539	1,468	76	205
Optional Eligibility	3.7	5,236	0	255	830	88	226
Children	**20.6**	**$19,869**	**$0**	**n/a**	**$2,482**	**$120**	**$2,059**
Mandatory Eligibility	16.4	15,886	0	n/a	2,045	89	1,572
Optional Eligibility	4.2	3,983	0	n/a	437	31	487

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

Notes: Does not include the U.S. Territories. Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments. Because of EPSDT requirements, we assume that 100% of expenditures for children for dental services, other practitioners, health clinics, and prescribed drugs is mandatory, and that 50% of expenditures for unspecified services ("other care") is mandatory. States are required to pay all or part of the Medicare premiums, deductibles, and copayments for certain low-income people age 65 and older and younger persons with disabilities who qualify for Medicare. No distinction is made between payments to mandatory and optional populations in this table because states are required to make these payments regardless of whether the individual is eligible for additional Medicaid benefits through a mandatory or optional eligibility category.

See endnotes for Table 1-2

Methods

Analyzing the likely impacts of this proposal is difficult for several reasons. To begin with, because the proposal is not specified in much detail, it is necessary to make several assumptions about what is intended. Further, we only assess the effects of Categories I and II, because the possibilities under Category III are too open ended to allow for any meaningful analysis.

More importantly, data available from the Health Care Financing Administration does not readily permit estimation of the expenditures on mandatory and optional populations or on mandatory and optional services. The first problem is that expenditure data are provided on adults and children in terms of their cash and non-cash status, not whether they are mandatory

or optional. While states must cover most cash recipients, they are also required to cover many pregnant women, children, and some parents who are not cash recipients. Other non-cash recipients are optional, e.g., children in families with incomes above the mandatory coverage guidelines and parents with incomes above mandatory Section 1931 standards.

Because the data are not reported by the categorization used in the NGA proposal, we used the Urban Institute's TRIM microsimulation model to estimate the percentage of children in families with incomes below the mandatory coverage guidelines. Using HCFA 2082 data we were able to estimate that spending per enrollee for optional and mandatory children were approximately the same. Using this information we were able to allocate expenditures to mandatory and optional eligible children. The second problem is that a large amount of expenditures are reported as prepaid health care services. These prepaid health care services include services that are both mandatory and optional in Medicaid. Since most expenditures covered by managed care plans are for mandatory services such as hospital inpatient and outpatient care, physician services, and laboratory and x-rays, we assume that 80% of expenditures on prepaid health services are for mandatory acute care services.

The third problem is that the EPSDT provisions of Medicaid require that any service deemed necessary as a result of the screening must be provided. As a result, a large share of "optional services" for children are, in fact, mandatory. However, data are not provided on how much of these "optional" expenditures are actually mandatory. We make the assumption that 100% of prescription drugs, dental, clinic and other practitioner services and 50% of "other care" are effectively mandatory.

Finally, the most recent data that is available in sufficient detail to disaggregate expenditures in ways envisioned by the NGA proposal is from 1998. The Congressional Budget Office's most recent baseline revision suggests that Medicaid spending will be 28.3% higher in 2001 (than in 1998) and 39.5% higher in 2002. We use 1998 data in this paper to describe the distribution of current spending, but project expenditures to 2001when we simulate possible fiscal effects of the proposal.

Current Spending

The distribution of current spending is presented in Tables 1 and 2. Table 1 shows that Medicaid spent $154.4 billion on services in 1998. There was additional spending (not shown) of $22.5 billion on disproportionate share hospital payments and administrative costs. Of the $154.4 billion, only 35% of Medicaid spending is for mandatory services for mandatory eligibles ($54.0 billion of $154.4 billion). This mandatory spending included $49.6 billion on mandatory acute and long-term care servicesand $4.4 billion on payments to Medicare (also mandatory).

The majority of Medicaid spending (65%) was for optional groups and benefits. Of the $100.4 billion in optional Medicaid spending, $32.0 billion is for optional services for mandatory groups. The remainder, $68.4 billion, is spent on optional eligibility categories, with, $47.3 billion for services that are considered mandatory benefits in Medicaid and $21.1 billion on optional services.

The Medicaid program spends $46.1 billion on the elderly; of this only $8.0 billion is mandatory spending for the elderly SSI population that states are required to cover. Of the mandatory spending on the elderly, $2.7 billion, or 33.8%, pays required Medicare premiums and fills in Medicare's deductible and co-payments. Medicaid spends an additional $4.5 billion on optional services for mandatory groups, including $1.3 billion for prescription drugs. The bulk of the funds spent on the optional elderly categories is for care provided in nursing homes. Of the $35.2 billion spent on the optional elderly groups, $28.2 billion is for long-term care (Table 2) of which $25.1 billion (not shown) is for nursing homes.

Medicaid spends $67.7 billion on the blind and disabled; of this $44.2 billion was spending for mandatory groups (SSI beneficiaries); the remaining $23.5 billion is for optional groups. For mandatory groups, Medicaid covers a wide range of acute care services, both mandatory and optional. Mandatory Medicaid spending included $17.6 billion on acute care services for this population and an additional $1.8 billion in payments to Medicare. Another $9.6 billion was spent on optional acute care services; of this amount, nearly half (46.2%) was for prescription drugs. Medicaid also spent $15.5 billion on long term care services for the mandatory blind and disabled; of this only $3.5 billion was for mandatory services. Of the $12.0 billion in expenditures for optional long-term care services, the largest share was spent on home and community based waiver services.

Of the $23.5 billion in services provided to the optional blind and disabled enrollees, spending is about 40% for acute care and 60% for long-term care services. The most important acute care services include hospital inpatient care and prescription drugs; the major optional services are ICF-MRs and home and community based waiver services.

For adults and children Medicaid provides predominately acute care services and most of the spending is on mandatory groups. For adults, $12.5 billion out of $16.0 billion was for mandatory services and for children, $19.1 billion out of $24.6 billion. The remaining spending on adults and children was for optional services. For adults a significant share of this was spending for prescription drugs (26.9%). For children we assumed that prescription drug spending as well as most other optional acute care spending was essentially mandatory because of EPSDT requirements.

The key finding from Tables 1 and 2 is that only 35% of Medicaid spending is for mandatory services for mandatory groups. States, at their own option, provide care to a large number of groups that they are not required to cover as well as a wide range of services that they are not required to provide. Given the nature of the optional services that are provided it is clear that states either view them as a critical part of the Medicaid benefit package, e.g., prescription drugs, or have found it advantageous to include them as benefits because they would otherwise have been funded wholly through state funds, e.g., care in intermediate care facilities for the mentally retarded or in inpatient psychiatric hospitals for children under the age of 21. Other optional services have significant political support, and thus have been attractive to add and difficult to cut, e.g., chiropractors, prosthetic devices, home health care, respiratory care for ventilator dependent individuals and hospice services.

Fiscal Implications of the NGA Proposal

The NGA proposal would shift a substantial share of the cost of Medicaid to the federal government and, at the same time, would change the incentives states have to expand and contract the program. Most of this shift in costs is due to the increase in the matching rate, not the additional flexibility provided to states. The first row of Table 3 shows that if states were to make no changes in covered populations, benefit packages or provider payments, state spending would fall by $16.5 billion and federal spending would increase by a like amount based on projections for 2001. This shift occurs because of the enhanced match on optional services for mandatory groups and on all services provided to optional eligibles. As shown in Tables 1 and 2, the enhanced match would go primarily toward optional spending for elderly and disabled beneficiary groups and predominately toward long-term care because this is where the bulk of current optional spending occurs.

The question this change poses is whether there is any justification for shifting so much spending to the federal government in the absence of any other changes in state policies, e.g., expanding coverage. The argument would be that Medicaid spending grows faster than state per capita incomes and state tax revenues. This has been generally true since the program began but much of this growth has been due to states shifting services into Medicaid to obtain federal matching funds. Some growth in spending in the last decade has been due to increases in disproportionate share payments and more recently, upper payment limit programs which have generated federal matching funds with little or no real state contribution. Much of the ability to use these arrangements has now been restricted by federal legislation. States are now faced with rising prescription drug costs, growing aged and disabled populations, and the Olmstead decision which requires states under the Americans with Disabilities Act to provide more services to the disabled in their communities.[1] Meanwhile, early savings from shifting to managed care seem to be gone and managed care has become less and less effective at containing the growth in health care costs in Medicaid, and more generally.

States now see that problems of rising costs are going to continue and possibly accelerate. They see Medicaid spending growth as a threat to their other priorities, e.g., education, corrections and transportation. The result is that states could increasingly underfund Medicaid, possibly reduce coverage and certainly not expand much despite new opportunities in the current program structure to do so.

One of the reasons that Medicaid spending grows faster than state tax revenues is the tendency of many states to rely on sales and property taxes, revenue sources that tend to grow more slowly than income. Use of these revenue sources makes Medicaid a constant budget issue and contributes to chronic funding problems as well as to efforts to shift spending to the federal government. Further complicating state decision-making are expenditure caps as in states like Colorado and Washington. While states are themselves to blame for their tax and expenditure constraints, it is health care for low-income populations that is affected.

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[1] See Bruen, B. and J. Holahan. "Medicaid Spending Growth Remained Modest in 1998, but Likely Headed Upward." (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2001).

Figure 1

Mandatory Populations: Medicaid Benefits and Allowable Cost-Sharing

Beneficiary Group	Allowable Cost-Sharing	Mandatory Benefits	Optional Benefits*
• **Children** (Federal minimum income levels)	None • Premiums: none	***Acute Care*** • Physicians' services • Inpatient hospital • Laboratory and x-ray • Outpatient hospital • EPSDT • Family planning services and supplies • FQHC and RHC • Nurse midwife • Certified nurse practitioner ***Long-Term Care*** • Nursing facility for individuals age 21+ • Home health for individuals entitled to nursing facility care	***Acute Care*** • Prescribed drugs • Medical/remedial care by licensed practitioners • Diagnostic, screening, preventive and rehab services • Clinic services • Dental care; dentures • Physical therapy and related care • Prosthetic devices • TB-related care • Primary care case management • Other specified medical/remedial care ***Long-Term Care*** • ICF/MR • Inpatient and nursing facility services for individuals age 65+ in an institution for mental disease • psychiatric hospital services for individuals < age 21 • Home health • Case management • Respiratory care for ventilator-dependent individuals • Personal care • Private duty nursing • Hospice • PACE services • HCBS
• **Adults in Families with children** (Section 1931 and TMA) • **Disabled** (SSI beneficiaries; certain working disabled) • **Elderly** (SSI beneficiaries)	• Deductible: $2/month per family • Co-payment: $0.50-$3.00 • Co-insurance: 5% of state's payment rate • Categories exempt from cost-sharing: - Pregnancy-related services - Emergency services - Family planning - People receiving hospice care - Inpatients required to contribute most of their income to the cost of their care		
• **Pregnant Women** (<133% FPL)	None for services that are mandatory for this group	Services related to pregnancy and other conditions which may complicate pregnancy	Other mandatory and optional Medicaid benefits
• **Medicare Buy-In** (QMB, SLMB, QI-1, QI-2)	N/A	• Medicare Part B premium • Medicare cost-sharing (QMBs only)	Full Medicaid benefits (mandatory and optional) for poverty-related elderly and disabled

(*Under EPSDT rules, these optional benefits must be provided to children when needed based on a screening).

Figure 2

Optional Populations: Medicaid Benefits and Allowable Cost-Sharing

Beneficiary Group	Allowable Cost-Sharing	Mandatory Benefits	Optional Benefits*
• **Children** (>Federal minimums)	None	***Acute Care*** • Physicians' services • Inpatient hospital • Laboratory and x-ray • Outpatient hospital • EPSDT • Family planning services and supplies • FQHC and RHC • Nurse midwife • Certified nurse practitioner ***Long-Term Care*** • Nursing facility for individuals age 21+ • Home health for individuals entitled to nursing facility care	***Acute Care*** • Prescribed drugs • Medical/remedial care by licensed practitioners • Diagnostic, screening, preventive and rehab services • Clinic services • Dental care; dentures • Physical therapy and related care • Prosthetic devices • TB-related care • Primary care case management • Other specified medical/remedial care ***Long-Term Care*** • ICF/MR • Inpatient and nursing facility services for individuals age 65+ in an institution for mental disease • Inpatient psychiatric hospital services for individuals <age 21 • Home health • Case management • Respiratory care for ventilator-dependent individuals • Personal care • Private duty nursing • Hospice • PACE services • HCBS
• **Adults in Families with children** (>Section 1931 minimums) • **Disabled** (>SSI levels & home and community-based services) • **Elderly** (>SSI levels & home and community-based services)	• Premiums: none • Deductible: $2/month per family • Co-payment: $0.50-$3.00 • Co-insurance: 5% of state's payment rate • Categories exempt from cost-sharing: - Pregnancy-related services - Emergency services - Family planning - People receiving hospice care - Certain inpatients required to contribute most of their income to the cost of care		
• **Certain Working Disabled** (>SSI levels)	States can set premiums and cost-sharing on a sliding scale based on income. • For individuals between 250% and 450% FPL, premium cannot exceed 7.5% of annual income • For individuals with incomes above $75,000, premium can equal 100% the cost of Medicaid coverage		
• **Elderly Nursing Home Residents** (> SSI levels)	None (under exemption for inpatients required to contribute most of their income to the cost of care)		
• **Pregnant Women** (>133% FPL)	None for services that are mandatory for this group	Services related to pregnancy and other conditions which may complicate pregnancy	Other mandatory and optional Medicaid benefits
• **Medically Needy**	• Premiums up to $19 per month, depending on family income and size • Deductible: $2 per month per family • Co-payment: $0.50-$3.00 • Co-insurance: 5% of state's payment rate • Categories exempt from cost-sharing: - Pregnancy-related services - Emergency services - Family planning - People receiving hospice care - Inpatients required to contribute most of their income to the cost of their care	• Prenatal and delivery services for pregnant women • Ambulatory services to individuals <age 18 and individuals entitled to institutional services • For all medically needy groups, either: 1. mandatory benefits package 2. any 7 of the Medicaid benefits categories	Other mandatory and optional Medicaid benefits

(*Under EPSDT rules, these optional benefits must be provided to children when needed based on a screening).

Table 3

Federal and State Expenditures Under Alternative Responses to NGA Proposal

(expenditures in billions)

	Enrollees (in millions)			Expenditures								
				Federal			State			Total		
	Current Total	Change	% Change	Current Total $	Change in $	% Change	Current Total $	Change in $	% Change	Current Total $	Change in $	% Change
Responses												
1. No Change in Services	**40.3**	**0**	**0%**	**113.3**	**16.5**	**14.6%**	**84.8**	**-16.5**	**-19.5%**	**198.0**	**0.0**	**0.0%**
Mandatory Eligibles	28.6	0	0%	63.1	5.3	8.3%	47.2	-5.3	-11.1%	110.3	0.0	0.0%
Optional Eligibles	11.7	0	0%	50.2	11.2	22.4%	37.6	-11.2	-29.9%	87.7	0.0	0.0%
2. No Change in Services – Expansion to 100% FPL	**40.3**	**6.4**	**16%**	**113.3**	**28.0**	**24.7%**	**84.8**	**-11.5**	**-13.6%**	**198.0**	**16.5**	**8.3%**
Mandatory Eligibles	28.6	0	0%	63.1	5.3	8.3%	47.2	-5.3	-11.1%	110.3	0.0	0.0%
Optional Eligibles	11.7	6.4	55%	50.2	22.8	45.4%	37.6	-6.3	-16.7%	87.7	16.5	18.8%
3. No Change in Services – Expansion to 200% FPL	**40.3**	**13.9**	**34%**	**113.3**	**39.7**	**35.1%**	**84.8**	**-6.5**	**-7.7%**	**198.0**	**33.2**	**16.8%**
Mandatory Eligibles	28.6	0	0%	63.1	5.3	8.3%	47.2	-5.3	-11.1%	110.3	0.0	0.0%
Optional Eligibles	11.7	13.9	119%	50.2	34.5	68.7%	37.6	-1.3	3.4%	87.7	33.2	37.9%
4. Mandatory Only	**40.3**	**-11.7**	**-29%**	**113.3**	**-73.7**	**-65.0%**	**84.8**	**-55.1**	**-65.0%**	**198.0**	**-128.8**	**-65.0%**
Mandatory Eligibles	28.6	0	0%	63.1	-23.5	-37.2%	47.2	-17.6	-37.2%	110.3	-41.1	-37.2%
Optional Eligibles	11.7	-11.7	-100%	50.2	-50.2	-100.0%	37.6	-37.6	-100.0%	87.7	-87.7	-100.0%
5. Mandatory Plus	**40.3**	**0**	**0%**	**113.3**	**12.8**	**11.3%**	**84.8**	**-18.1**	**-21.3%**	**198.0**	**-5.2**	**-2.6%**
Mandatory Eligibles	28.6	0	0%	63.1	3.8	6.0%	47.2	-5.9	-12.4%	110.3	-2.1	-1.9%
Optional Eligibles	11.7	0	0%	50.2	9.0	18.0%	37.6	-12.2	-32.4%	87.7	-3.1	-3.6%

Source: Urban Institute estimates (2001), based on data from federal fiscal year 1998 HCFA-2082 and HCFA-64 reports. Expenditures projected to 2001, based on CBO estimates.

Notes: Does not include the U.S. Territories. Expenditures do not include disproportionate share hospital (DSH) payments,administrative costs, or accounting adjustments.

Explanation of response alternatives:

1. Assumes no change in covered populations or covered services, only enhanced match.

2. Assumes no change in covered populations or covered services, but adds coverage for all people to 100% FPL, with enhanced match.3. Assumes no change in covered populations or covered services but, adds coverage for all people to 200% FPL, with enhanced match.

4. Assumes states cut back to cover only mandatory eligibles for mandatory services.

5. Assumes states cover mandatory eligibles and mandatory services, and all current long term care services but make a 30% cut in optional services to optional eligibles and a 10% cut in optional services to mandatory eligibles.

Finally, states have incentives to make efforts to attract high-income taxpayers and new businesses by keeping tax rates lower than their neighbors. The inevitable interstate competition can lead to underspending on income distribution programs. To avoid such problems, it has often been argued that income transfer programs should be financed at higher levels of government.[2] Thus, while rising health care costs are a problem at the federal level as well, these financing issues can be debated in an environment free of concerns about interstate competition. If these arguments hold true, then a case can be made that more of the care for low-income families, and low-income disabled and elderly people should be paid for at the federal level.

The second major implication of the NGA proposal is that, because state matching requirements are reduced by 30%, the cost of any expansion of coverage is reduced. Under the NGA proposal states could expand coverage to parents and childless adults and could extend coverage to both children and adults to higher income levels. States could, because of the enhanced matching rate, substantially increase coverage with little or no new money.

The second row in Table 3 shows that states could expand coverage to 100% of poverty for all children and adults and still spend less than they do today. Based on simulations using Current Population Survey data, we estimate that an expansion to 100% of the federal poverty line would add coverage of 6.4 million new enrollees at a cost of $16.5 billion. But because of the reduction in the state match on existing optional services and the lower match on new enrollees, state spending would actually still fall by $11.5 billion. New federal expenditures would increase from $16.5 to $28.0 billion. Because the additional cost of new enrollees would now be 30% lower, and because of the enhanced match on optional services, states could still save money despite an expansion of coverage. As a result the incentives to do so are quite strong.

The third row shows that states could also expand coverage to 200% of poverty for all adults and children and still come out ahead financially. We estimate that an expansion to 200% of poverty will add coverage of 13.9 million new enrollees for a total cost of $33.2 billion. States would save $6.5 billion, again because of enhanced match on all services provided to optional groups as well as optional services to mandatory groups and because of the lower match on the new enrollees. The cost to the federal government of both the enhanced match for existing and new coverage would be $39.7 billion.

At the same time, incentives facing states considering cutting back on benefits are also reduced. The possibility of cuts in coverage and benefits is a great concern to many observers about the NGA proposal. But states would save 30% less from every dollar of reduction in benefits and provider payment than they do today. The fourth row shows the worst case; if one assumes that states would cut all optional services for mandatory groups and all services for optional groups then program spending would drop by $128.8 billion. The federal and state governments would each save almost 65% of current spending on Medicaid. But since states do not have to cover these populations nor these services now and would receive a 30% higher matching rate, it is highly unlikely that this would occur.

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[2] See Peterson, Paul E. "The Price of Federalism" (Washington, DC: Brookings Institution, 1995) and Rivlin, Alice M. "Reviving the American Dream: The Economy, the States & the Federal Government" (Washington, DC: Brookings Institution, 1992).

It is more likely that states would cut back on some optional acute care services for mandatory groups and more so for optional groups; except for the medically needy, states are required to provide optional services to optional groups if they provide them to mandatory groups. For example if a state provides dental coverage to mandatory groups, it must provide dental benefits to any optional groups it covers. If we assume that with the new flexibility in this proposal, states make a 30% cut in optional services provided to optional groups and a 10% cut in optional services provided to mandatory groups, then overall program spending would fall by $5.2 billion, or 2.6%. These reductions could include a combination of elimination of some services, reductions in amount, duration and scope of some benefits, as well as additional cost sharing. Under this assumption, states would save $18.1 billion, or 21.3% of current program spending.

Most of the savings, however, are because of the enhanced match on the optional services that remain, not the elimination of previously covered services. Of the $18.1 billion, only $2.4 billion comes from savings from the cuts in services or from cost sharing; the remainder or $15.7 billion is from the enhanced match. Surprisingly, even though fewer services would be provided, federal government spending would increase by $12.8 billion, or by 11.3%, because the enhanced match on the remaining optional services and optional populations would more than offset the elimination of some covered services.

Issues with the NGA Proposal

This analysis examines the NGA proposal focusing on increases in state flexibility together with the enhanced match for optional spending. The incentives and risks to beneficiaries change significantly if the enhanced match rate portion of the proposal is dropped due to its cost. As put forward by the governors, the incentives to expand coverage seem to be significantly enhanced while the incentives to contract are substantially reduced. However, in the absence of the enhanced match, the new incentives to maintain or expand coverage are gone.

Even with the enhanced match, the NGA proposal is not without its problems. First, there is the distinct possibility that there could be a large increase in federal spending with no gain in coverage. This follows from the fact that states need not expand coverage at all to obtain the higher match.

Second, states could reduce coverage or benefits despite the arguments made above about the changes in incentives. States faced with fiscal pressures could limit benefits or impose cost-sharing in ways not permitted under current law and receive more federal dollars, while spending fewer state dollars. States would have the flexibility to do so and no doubt some might take advantage leaving the federal government to spend more with less coverage and fewer benefits. Given the large fiscal transfer states seek, it would not be unreasonable for the governors to offer broader minimum standards for coverage and benefits in exchange for the higher federal matching payments, e.g., coverage of all individuals below poverty and inclusion of prescription drugs as mandatory service. As shown in Table 3, states would still easily come out ahead financially because of the matching rate changes.

Third, the differential matching rates for mandatory versus optional populations create poor incentives, extending the problem we now have with the S-CHIP program to a larger population.

Under the NGA proposal, there are better incentives to cover the near poor than the mandatory-eligible poor. States also have strong incentives to "game the system" by enrolling people into the category with a higher matching rate. The argument given above is that states would have greater incentives to expand coverage at the margin because matching rates would be higher. But this would be equally true if matching rates were expanded for all current populations.

Fourth, the proposal would likely increase disparities in coverage in benefits among states. Given past history, it is likely that states would respond differently to this proposal. It is quite likely that we would see substantial expansions in coverage in many northeastern, midwestern, and far western states. At the same time, there could be no change or program cut backs occurring elsewhere.

Fifth, the proposal discusses a benefit package similar to S-CHIP but seemingly ignores the fact that the bulk of Medicaid spending is on the disabled and on individuals who are heavy users of long term care services. An S-CHIP benefit package, or the actuarial equivalent of a S-CHIP benefit package is not sufficient to meet the needs of these groups. It may be that the intent of the proposal is to provide an appropriate benefit package for disabled individuals but that is not clear from written documents that the NGA has provided.

Sixth, Category III, which would essentially allow the provision of any services to any groups, seems too open ended and could result in greatly increased federal spending. The rising expenditures could, as a result, cause the Congress to retrench on commitments made in the other two categories. Category III does offer the potential for a number of interesting innovations at the state level, e.g., the provision of catastrophic coverage above certain income levels and preventive care benefits, as well as for financial relief of safety net providers. But it could also result in states securing federal matching funds on a range of public health programs that are now state funded or even federal matching funds on state employee health benefits. Constraints on how these funds could be used would clearly be needed.

Finally, the proposal does not address the various creative financing vehicles the states have employed in recent years, e.g., disproportionate share payments and upper payment limit programs. Given the large increase in federal payments which they seek, agreement to end these arrangements seems appropriate. The proposal seems to allow any state to secure support for its safety net institutions by expanding coverage at the new highly attractive matching rates. There seems little need for continuing these controversial arrangements.

Conclusion

This brief has examined the fiscal implications of the core of the National Governors Association proposal to restructure the Medicaid program. The brief shows that the proposal, without consideration of Category III, would result in a transfer of $16.5 billion from the states to the federal government, assuming no changes in coverage or benefits. The enhanced match is the primary reason. The increase in federal spending of this magnitude raises obvious questions of political feasibility in the current budgetary environment and, furthermore, about whether this is the best use of federal dollars as opposed to, for example, expenditures directly for coverage expansion.

We also demonstrated that states could considerably expand coverage because of the enhanced match, and still spend less than they do currently. Further, we showed that states could make substantial reductions in currently optional services and increase their savings above that resulting from the enhanced match. Most of the savings however would still be from the enhanced match; indeed without the change in matching rates this is a very different proposal. We also showed that federal expenditures would increase substantially if states significantly expanded coverage and further, that federal expenditures would increase even if states made significant cutbacks because the enhanced match would more than offset the savings from reductions in benefits. In reality, some states would expand coverage and others may reduce services. Differences among states in coverage and benefits would be likely to expand. The true impact on federal and state spending would be extremely hard to predict.

Despite the several issues we have raised, the NGA proposal raises serious issues that merit consideration. It raises legitimate issues about the appropriate roles of federal and state governments in financing of health care for low-income families, disabled and elderly. An argument can clearly be made supporting a greater federal financial role. The proposal would also fundamentally alter the financial incentives facing states. The changes in matching rates that states seek could also usefully increase incentives for states to expand their programs to cover more of the uninsured as well as reduce the incentives to contract coverage, benefits, and provider payments when under financial stress. Thus while it is hard to envision enactment of the NGA proposal as written, it may well contribute to the debate over how to both support and extend public insurance coverage for low income populations.

Endnotes

1) Mandatory acute care services include inpatient and outpatient hospital services, FQHC and rural health clinic services, physician services, laboratory and radiology services, early and periodic screening, diagnostic, and treatment (EPSDT) services, family planning (including sterilizations), nurse midwife, and nurse practitioner services. This analysis assumes that 80% of expenditures of prepaid health care services (e.g., HMO, HIO, and PHP programs) are for mandatory acute care services. This analysis also assumes that 100% of expenditures for children for dental services, other practitioners, health clinics, and prescribed drugs is mandatory due to EPSDT requirements, and that 50% of expenditures for unspecified services ("other care") is mandatory.

2) Because of EPSDT, prescription drug spending for children is included under mandatory spending.

3) Optional acute care services include other practitioners' services (e.g., podiatrists, optometrists, chiropractors), private duty nursing, clinic services (except FQHC and rural clinic services), dental services, physical therapy, occupational therapy, speech, hearing, and language disorder services, dentures, prosthetic devices, eyeglasses, rehabilitative services, Christian Science practitioners, hospice services, targeted case management, primary care case management (PCCM), emergency hospital services, and otherservices as allowed by state Medicaid plans.

4) Mandatory long-term care services include nursing facility services for people age 21 and older and home health services.

5) Optional long-term care services include nursing facility services for people under age 21, intermediate care facility services for the mentally retarded (ICF-MR), inpatient psychiatric services for people under age 21, inpatient hospital services and nursing facility services for people over age 65 in mental institutions, personal care services, home- and community-based services for functionally disabled elderly individuals, home- and community-based waiver services, targeted case management, and private duty nursing.

6) Mandatory coverage groups include people receiving SSI (or in states using more restrictive criteria, people age 65 and older and younger people with disabilities who meet criteria which are more restrictive than those of the SSI program), low-income families with children who meet certain of the eligibility requirements in the state's AFDC plan in effect on July 16, 1996, infants (up to age 1) born to Medicaid-eligible pregnant women, children under age 6 and pregnant women with family incomes at or below 133 percent of the Federal poverty level (FPL), and children under age 19 and born after September 30, 1983, with family incomes at or below the FPL, recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, certain Medicare beneficiaries, and special protected groups who may keep Medicaid for a period of time after a change in status.

7) Optional enrollees include infants up to age one and pregnant women not covered under the mandatory rules with family incomes below 185 percent of the FPL, optional targeted low income children, certain people over age 65 and younger people with disabilities who have incomes above those requiring mandatory coverage but below the FPL, children under age 21 who meet income and resource requirements for AFDC, but who are not otherwise eligible for AFDC, institutionalized individuals with income and resources below specified limits, people who would be eligible if institutionalized but are receiving care under home and community-based services waivers, recipients of state supplementary payments, and certain TB-infected individuals.

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