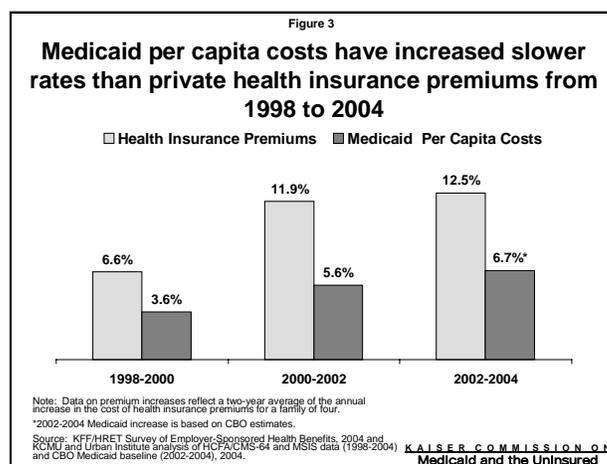
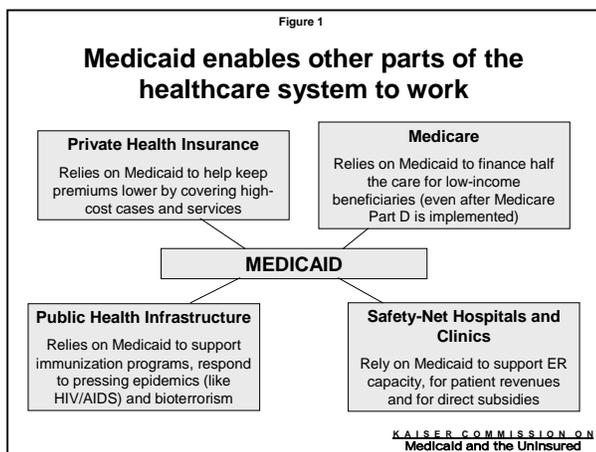


MEDICAID: ISSUES IN RESTRUCTURING FEDERAL FINANCING

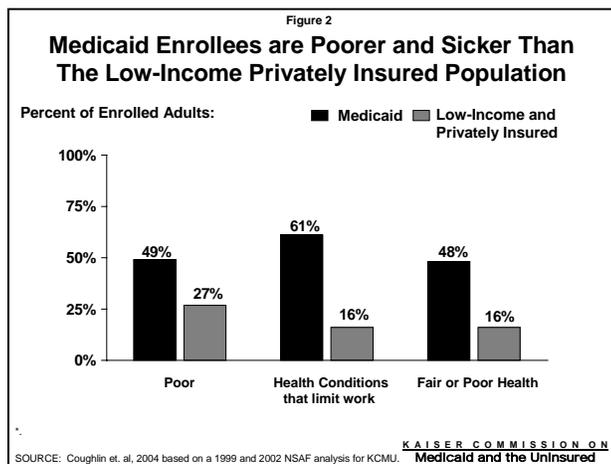
Our nation's healthcare system relies on Medicaid to finance care for the low-income population and through their care to support providers, private health insurance, the Medicare program and the nation's public health infrastructure. (Figure 1) Pressures to reduce the federal deficit may cause policy makers to consider significant changes in the Medicaid program but these changes should be balanced against the role Medicaid plays in the nation's increasingly stressed healthcare system.

While many argue that Medicaid costs are too high, Medicaid per capita growth has been consistently about half the rate of growth in private insurance premiums. (Figure 3) Compared to private health programs, Medicaid also has far lower administrative costs. Both of these factors show that despite program growth, Medicaid is a fairly efficient program. Recent program growth has been fueled by increased enrollment as a result of the economic downturn and not increasing per capita costs.



Over the last 40 years, Medicaid has evolved to meet the health and long-term care needs for one in ten Americans including people with low-incomes, the working poor and their children, the elderly, and the disabled. Individuals on Medicaid tend to be poorer and sicker than those covered by private insurance. Without Medicaid, many more low-income individuals would be uninsured, adding additional stress to the health care system. (Figure 2)

In the past, fiscal pressure at the federal level has led to attempts to limit federal Medicaid spending by decreasing matching payments, placing caps on spending or imposing mandatory percentage reductions to the program. Such efforts may resurface in the year ahead as policymakers face a growing federal budget deficit. Budget decisions at the federal level that result in reductions in federal support for Medicaid could limit states' capacity to provide health coverage to low-income families, respond to unpredictable situations and support providers at levels that promote accessible and affordable health care.



THE FEDERAL DEFICIT AND THE POTENTIAL IMPACT ON MEDICAID

In January 2001, the Congressional Budget Office (CBO) projected that there would be a surplus in FY 2004 of \$397 billion. However, by 2004, the federal government had a deficit of \$413 billion. Over the next decade, 2005 to 2014, the CBO estimates that the deficit will total \$2.3 trillion. Alternative projections that include the extension of certain tax cuts that are set to expire would increase those deficit projections to \$4.4 trillion over the period.

During the 109th Congress, policymakers will need to make decisions that will shape the size of the federal deficit and tax policy. Entitlement programs, like Medicare and Medicaid, are likely to be targeted to meet the Administration's commitment to cut the federal deficit in half over the next five years and to support tax changes.

Many budget priorities may be determined in March or April as part of the budget resolution which is the "blueprint" that determines federal spending and revenue levels. Later in the year, Congress may consider "reconciliation" bills that determine how to achieve the budget resolution targets. Special rules (such as limited debate time and passage with a majority vote) apply to reconciliation bills in the Senate. A target for Medicaid reductions could be included in the budget resolution and the reconciliation bills would provide more detail on specific program changes.

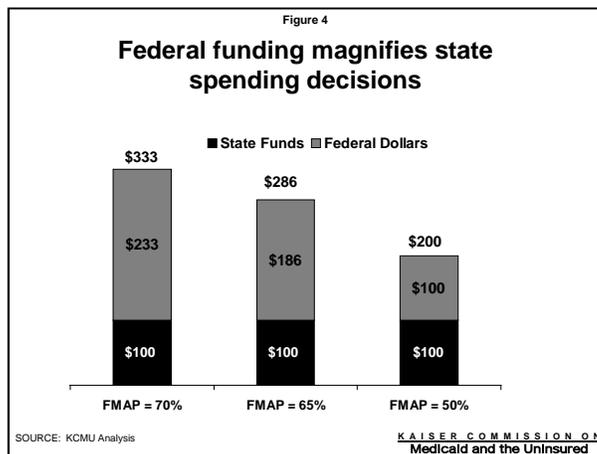
Medicaid accounted for 8 percent of federal outlays in 2004 (while Medicare accounted for 12 percent and Social Security at 21 percent). Over the next decade Medicaid is expected to increase from 1.5 percent of GDP to 2 percent of GDP, so, while a substantial federal commitment, it is not a dominant contributor to the overall deficit projections.

CURRENT MEDICAID FINANCING STRUCTURE

The current Medicaid financing structure has several key design features that support national healthcare objectives:

- States and the federal government share the risk and responsibility for paying for the costs of caring for populations covered by Medicaid;
- Federal financing is guaranteed to states based on the federal matching percentage (FMAP) and state spending. This gives states capacity to respond to changes in economic conditions, demographics, disasters and epidemics;
- Guaranteed matching payments create incentives to invest in health care and discourage reductions in coverage, and
- State financial obligations act as a constraint on federal spending since states have incentives to control costs.

Under the current structure, states with a 50 percent match rate receive an additional \$100 from the federal government for every \$100 they pay for Medicaid, and states with a 70 percent match rate receive \$233 from the federal government for every \$100 that they spend. When states reduce state Medicaid spending, they lose federal revenue. (Figure 4)



WHAT IS AT STAKE FOR STATES?

Medicaid is a major source of coverage for low-income individuals but also serves as an engine in state economies supporting millions of private sector jobs. Medicaid is the largest source of federal revenue to states, representing 44 percent of all federal revenue to states.

Under current law, states have a lot of flexibility to design and administer their Medicaid programs. In fact, about two-thirds of all Medicaid spending is for "optional" services or populations. Every state covers some set of optional services or people (like prescription drugs or poor seniors).

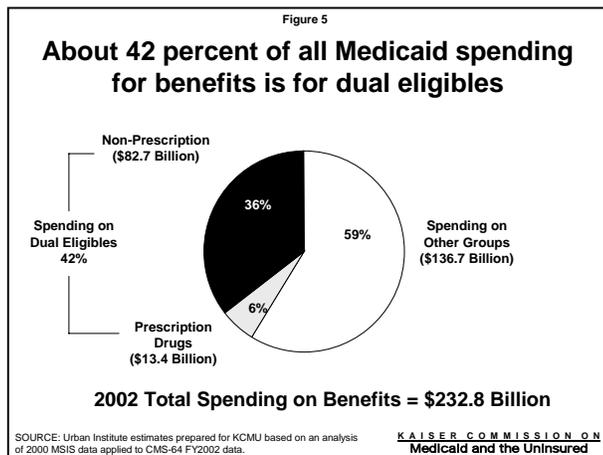
States currently can use Medicaid program flexibility to: expand or reduce eligibility, enhance or limit benefits, increase or reduce provider payments, change care patterns or shift costs. However, despite the flexibility in the law, Medicaid covers medically necessary services provided to low-income or very sick individuals and it is hard to use flexibility to limit Medicaid without dealing with consequences such as increases in the uninsured, increases in uncompensated care costs, barriers to access, limited provider participation, or poor quality care.

If federal revenues were limited, states would have to decide whether they should increase their own funds for health care or make cuts to the Medicaid program. Even with fewer federal resources, states might still be held accountable for providing services to medically vulnerable populations like the dual eligibles. About 42 percent of all Medicaid spending for benefits is for elderly and disabled individuals who are dually eligible for Medicare and Medicaid. (Figure 5)

Additionally, states that have limited programs with few optional services would have a harder time making program reductions or expanding their programs in the future if federal support were capped based on current funding levels.

Finally, health care payments are extremely hard to predict due to new technology, changes in practice patterns, and

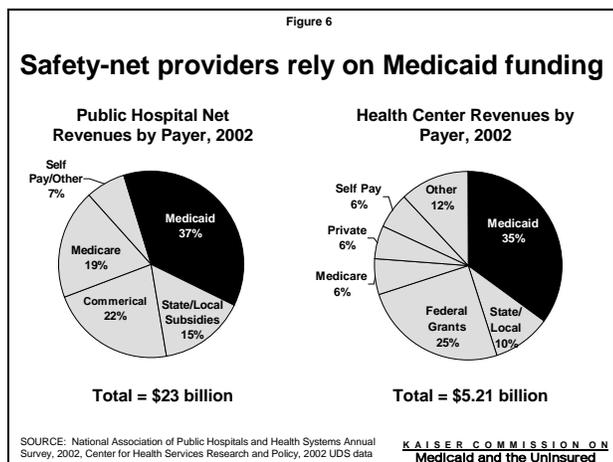
economic downturns. The State Children's Health Insurance Program (SCHIP), a capped entitlement to states, highlights the difficulty projecting spending needs and appropriately targeting funds to where they are needed most. Under SCHIP, the federal spending allotments exceeded spending in the early years of the program and now many states are expecting funding shortfalls in SCHIP over the next few years.



WHAT IS AT STAKE FOR PROVIDERS?

Medicaid accounts for one of every six dollars of health care spending and nearly one in every two long-term care dollars. Medicaid is also the country's major payer for mental health services, HIV/AIDS care, care for children with special needs and births. Like private health insurance, Medicaid purchases services from hospitals, physicians and other providers in the private healthcare market place. To even a greater extent than the private market, Medicaid enrolls many beneficiaries in managed care plans that have contracts with private providers. Medicaid is unlike Veteran's Affairs that operates its own health care facilities.

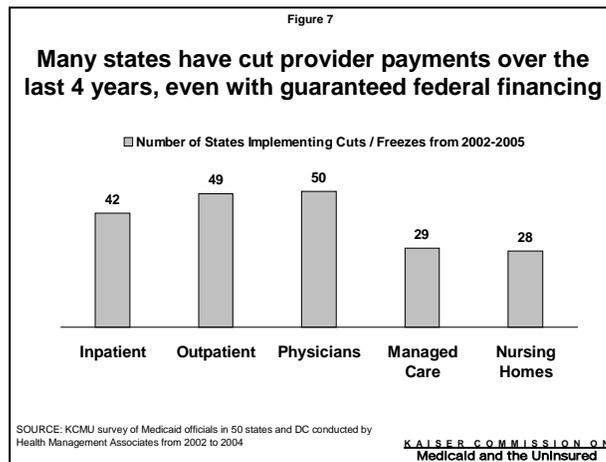
Many public hospitals, children's hospitals, rural providers and community health centers rely heavily on Medicaid revenue. (Figure 6)



Most providers already receive Medicaid payments that are lower than the cost of providing care to program beneficiaries. Most providers can shift these costs to other payers, but providers that rely more heavily on Medicaid cannot shift costs as easily as other providers. Many of these same providers also rely on Disproportionate Share Hospital (DSH) payments. These payments help hospitals that serve a disproportionate share of low-income or uninsured patients. Federal DSH payments are already capped.

Medicaid is the largest payer for long-term care (both institutional and community-based) and public mental health services. Because Medicaid represents such a large share of revenues for these provider types, they would be at a higher risk if federal Medicaid financing were reduced or capped.

In recent years, states have experienced sharp declines in state revenues and large budget shortfalls. In response to this fiscal stress, states implemented a number of efforts to control Medicaid costs. All 50 states and the District of Columbia have imposed some restrictions on provider payments over the last four years. Physicians, inpatient and outpatient payments were the most likely to be frozen or cut over the period. (Figure 7)

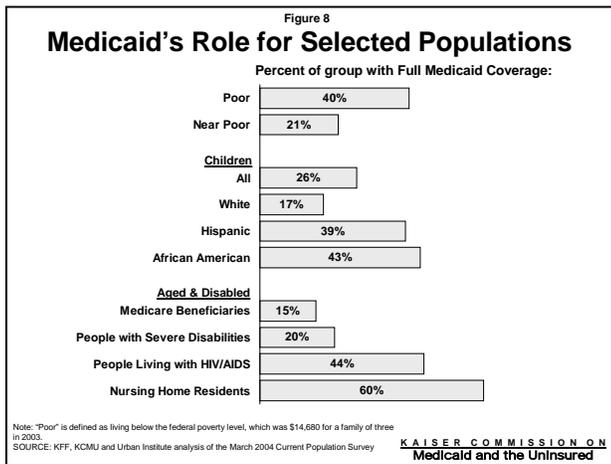


Limiting federal Medicaid resources would place additional pressures on providers, resulting in fewer providers able to serve Medicaid and uninsured patients. Increasing the differential between Medicaid and private insurance payments would result in less access for beneficiaries and could hamper needed efforts to improve quality of care.

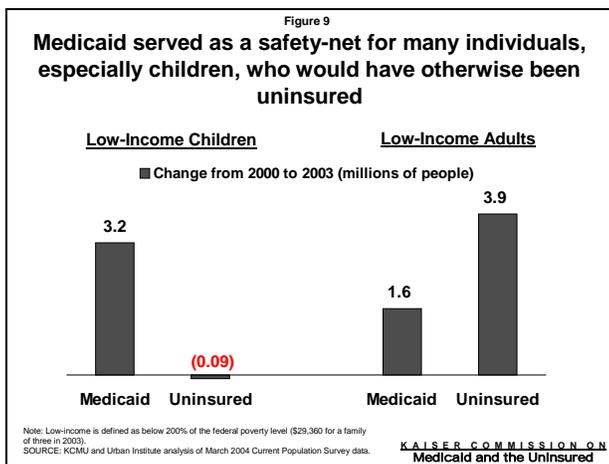
WHAT IS AT STAKE FOR BENEFICIARIES?

Medicaid is the dominant source of insurance coverage for many groups of individuals including the poor and near poor, children (especially Hispanic and African American children), and the elderly and people with disabilities (especially individuals in nursing homes and those living with HIV/AIDS). All of these groups would be at a high risk for either losing

coverage or access to essential benefits if federal Medicaid financing were restricted. (Figure 8)



Medicaid currently serves as a safety net for many individuals, especially children, who fall into poverty or lose their private health insurance. Without Medicaid, many more individuals would have become uninsured as a result of the recent economic downturn. From 2000 to 2003 the number of low-income children who are uninsured declined by 90,000 despite increases in poverty and declines in private health insurance. (Figure 9)

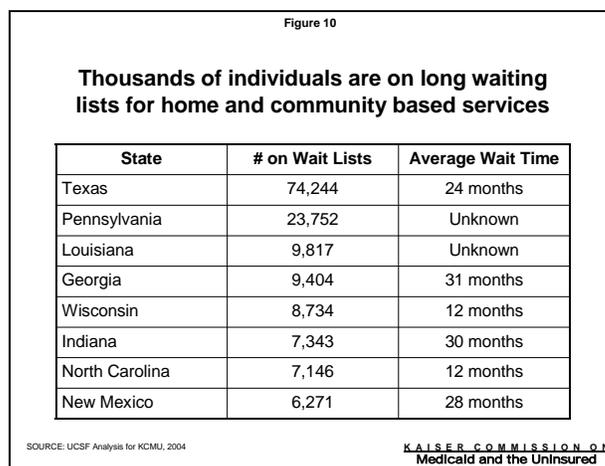


Additionally, Medicaid serves many elderly and people with disabilities who are among the poorest and sickest people in the country, including many who are also eligible for Medicare. These "dual" eligibles are sicker and need more services than other Medicare beneficiaries.

Each state provides Medicaid coverage to some "optional" populations or provides beneficiaries with some "optional" services. People with disabilities such as autism, schizophrenia, HIV/AIDS, cerebral palsy, Down's Syndrome and Parkinson's disease who would not be able to receive private health coverage are disproportionately represented among the "optional" people and services covered by Medicaid. Medicaid plays a special role for individuals with

mental health needs, accounting for about one-half of all public mental health funds.

Individuals with Medicaid have access to health care services and outcomes comparable to the privately insured. Recent program waivers provide states with additional flexibility to modestly expand eligibility but also to impose eligibility caps, reduce benefits or increase premiums and cost sharing. Recent 1115 waivers have tended to focus mostly on the cost-cutting approaches with very limited expansions. For home and community based waiver services, capped enrollment has resulting in long waiting lists of up to several years for services. This experience of waivers is a strong indicator of how states may behave to help alleviate state budget pressures if given additional flexibility without guaranteed federal financing. (Figure 10)



Without the current Medicaid financing structure, many individuals could lose their entitlement to health insurance coverage. Most would find it difficult to get affordable or adequate coverage to meet their needs in the private market. Most notably, long-term care benefits are typically not included in private health insurance plans. Clinics and other providers would face additional stress and without the resources to serve an increased number of uninsured.

OUTLOOK FOR THE YEAR AHEAD

During the upcoming budget debate, it is critical to weigh the implications of cuts in federal funding and fundamental changes in Medicaid at a time when there is no clear alternative to the program and the role it plays in the healthcare system. While some may argue funding for Medicaid needs to be constrained, others argue that Medicaid is currently under-funded to meet the responsibilities expected of the program.