Revised March 8, 1995 (11:03am)

MEDICAID BLOCK GRANT PROPOSAL

- Republicans are proposing to cap federal payments to states under the Medicaid program as part of their effort to balance the federal budget.

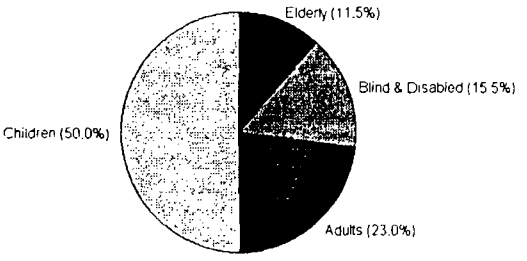
- House leaders have discussed a target of $180 - 190 billion in reduced federal contributions for Medicaid between 1996 and 2002. This is approximately equivalent to capping annual growth in federal Medicaid payments at 5% beginning in 1996.

  Senate leaders have discussed a target of about $75 billion in reduced federal Medicaid contributions between 1996 and 2000 (which would correspond approximately to a 6.5% cap).

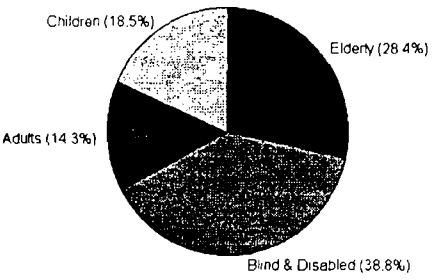
- While there are no specific Congressional block grant proposals for Medicaid, the presumption is that states would be given broad flexibility to determine eligibility, benefits, and provider payment levels.

CURRENT MEDICAID PROGRAM

Medicaid Beneficiaries and Expenditures: 1993



Beneficiaries: 32.1 million

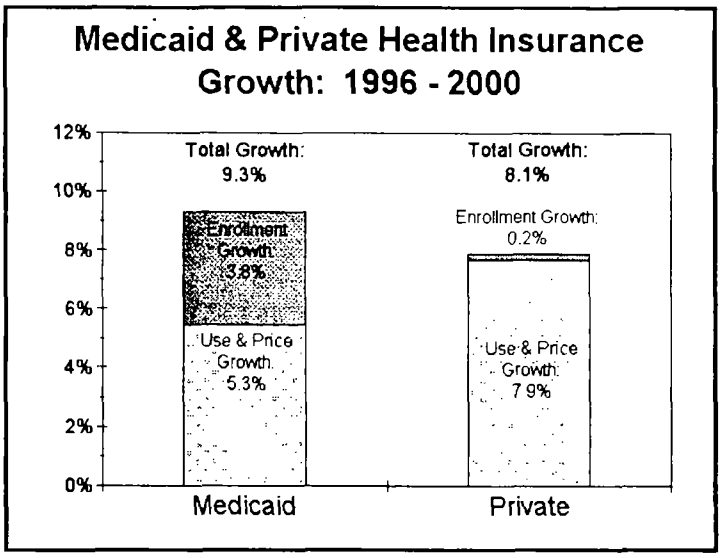


Non-DSH Expenditures: $108 billion

Note: Does not include Arizona or U.S. Territories
Source: The Urban Institute, 1994, Prepared for the Kaiser Commission on the Future of Medicaid

- Children and adults (non-elderly, non-disabled) comprise about three quarters of enrollment, but account for only one-third of spending (DSH excluded). Adults alone account for only about 14% of spending.
- The elderly and people with disabilities comprise only 27% of enrollment, but account for 67% of the spending.
- Long-term care services account for 35% of total Medicaid spending.

GROWTH IN MEDICAID ENROLLMENT



- Medicaid enrollment increases are responsible for the relatively high rates in Medicaid expenditure growth.

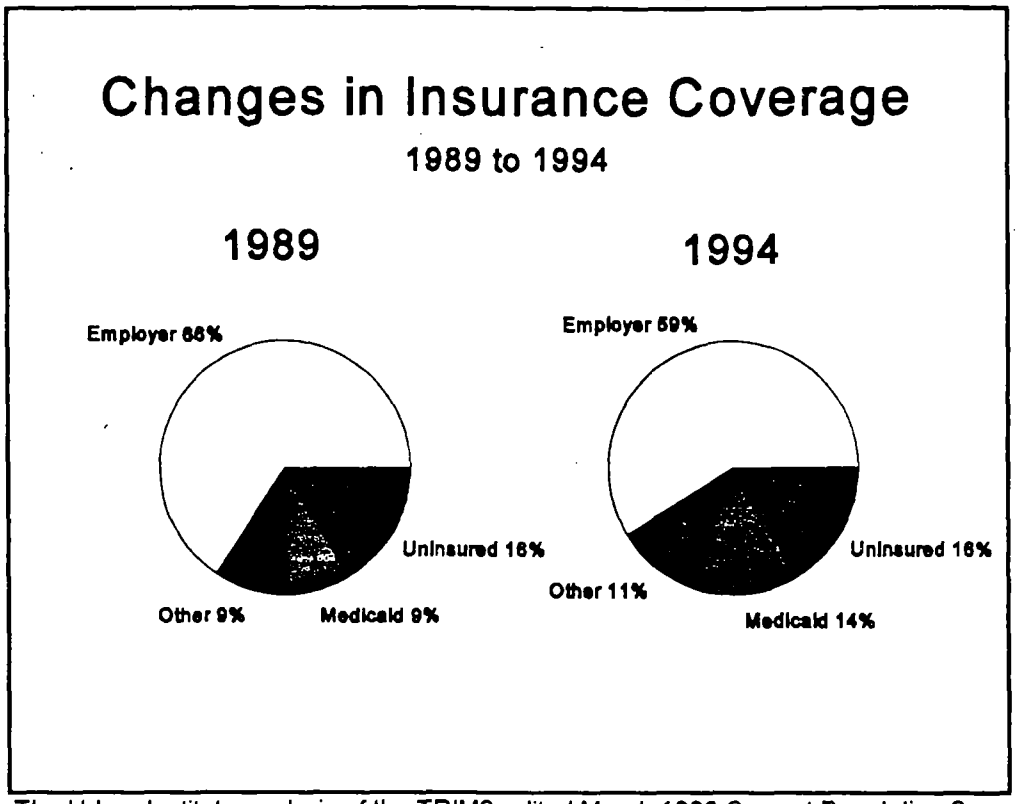
- On a per person basis, Medicaid actually is projected to grow at a slower rate than private health spending — about 5.3% annually per recipient as compared to about 7.9% annually per insured person.

- Medicaid is projected to cover an additional 10 million people by 2002 (for a total of 47 million people).

  - Between 1996 and 2000, the number of AFDC recipients covered by Medicaid is projected to grow 2.3% annually.

  - The number of aged and disabled recipients is projected to grow by 4.7% annually during the period.

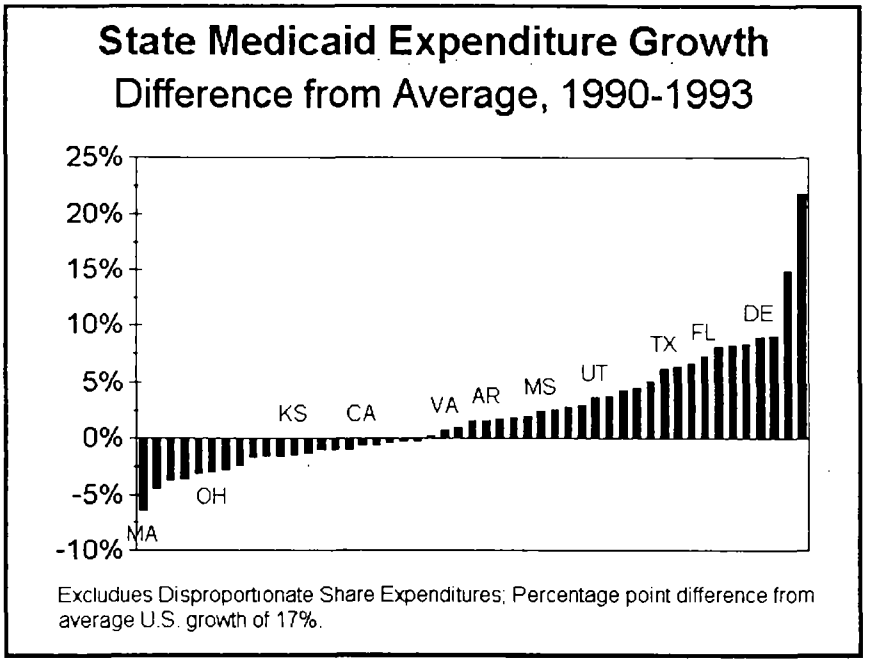
CHANGES IN MEDICAID ENROLLMENT



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

- Medicaid has been a significant and growing source of health insurance for many people.
  - Between 1989 and 1994, the percentage of the population covered by Medicaid grew from 9% to over 14%, while the percentage covered by private health insurance fell from about 66% to about 59%.
  - Without this growth in Medicaid, the number of uninsured would likely have increased significantly.
- Additional Republican proposals to significantly cut federal Medicaid payments through a block grant would likely exacerbate the loss of Medicaid coverage. The magnitude of the suggested cuts would leave states with little choice but to reduce eligibility and benefits.

STATE VARIATIONS IN GROWTH RATES



- The rate of growth in Medicaid spending varies significantly from state to state. Growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns, or service mix.

EFFECT OF A BLOCK GRANT

As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the number of people eligible in a state.

- **Block Grants Do Not Recognize Differences Among State Programs.**
  - State growth rates can vary significantly across states (e.g., for differences in population, regional medical costs, enrollment patterns, or service mix) and over time in a given state.
  - States also have very different opportunities to achieve savings through managed care. For example, some states already have achieved savings, rural states have less capacity to implement capitated payment arrangements, and some states have a larger proportion of elderly and disabled recipients (for whom managed care is largely untested).

- **States At Risk from Inflation and Recession.** When a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, federal payments to the state would rise, but under a block grant with a fixed growth rate they would not.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services for an increasing number of elderly people.

CAPPING MEDICAID SPENDING

Reduction of Federal Spending Under a 5% Growth Cap
(Billions of Dollars, Fiscal Years)

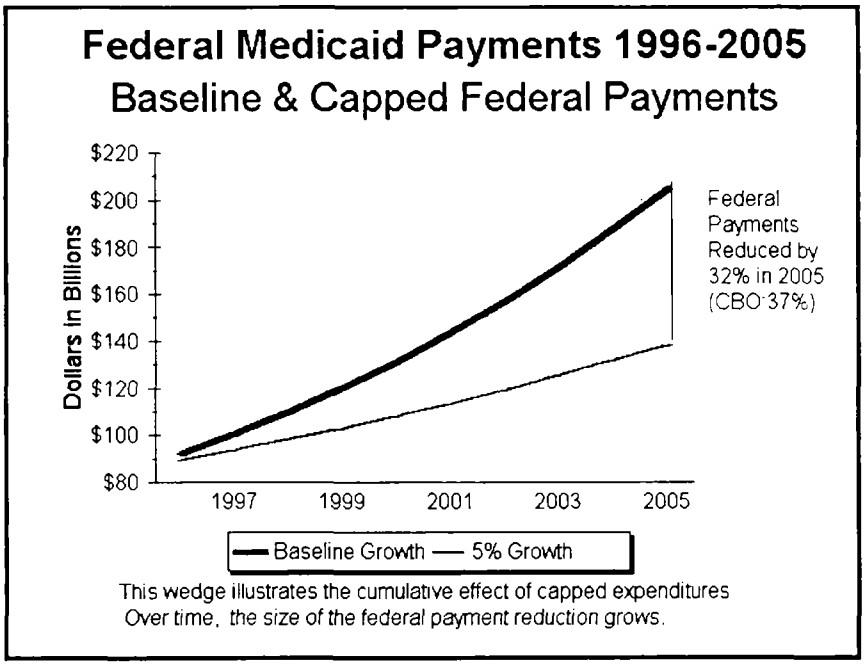
	1996-2000	1996-2002	1996-2005
CBO			
Baseline	$614	$955	$1,593
5% Growth	$518	$763	$1,178
Fed. Reduction	**$97**	**$192**	**$415**
Administration			
Baseline	$576	$890	$1,477
5% Growth	$513	$756	$1,168
Fed. Reduction	**$63**	**$134**	**$309**

- Under the President's baseline, Medicaid is projected to grow at 9.3% through 2002. This is a dramatic reduction from the over 20% annual average growth rate during the Bush Administration.

- Under the CBO baseline, Medicaid is projected to grow at 10.2% through 2002.

- Due to the cumulative effect of the annual reductions under a 5% rate of growth cap, the reduction in federal payments to states doubles (from $97 billion to $192 billion under the CBO baseline) between FY2000 and FY2002.

CAPPING MEDICAID SPENDING



- Over five years (1996 to 2000), federal payments to states would be 11% below the baseline projection (16% under the CBO baseline).
- Over ten years (1996 to 2005), the cumulative reduction in federal payments is 21% (26% under CBO baseline).
- In FY 2005 alone, federal payments to states would be 32% below the baseline projections (37% under the CBO baseline).

STATE-BY-STATE EFFECTS OF CAPPING FEDERAL MEDICAID PAYMENTS

- The state-by-state effects of capping federal Medicaid payments have been analyzed two ways.
  - The first method estimates the reduction in federal payments for each state assuming that federal payments to each state under the status quo would grow at the national rate of growth in Medicaid spending projected by CBO.
  - The second method estimates the reduction in federal payments for each state assuming that federal payments to each state grow between 1996 and 2002 at the same annual rate that the state is projecting for the period 1993 to 1996.
  - Note: The total reductions differ between the two methods because the second method is based entirely on state data (and is not controlled to Administration or CBO baselines).
- Assuming that all states grow at the projected national annual growth rate, a block grant with 5% growth would reduce federal payments in every state.
- Assuming state-specific growth rates, changing federal Medicaid payments into a block grant with 5% growth would disproprotionately harm states with high growth rates and benefit states with lower rates of growth.
  - For example, Texas, which has a high rate of growth, would lose almost $21 billion between 1996 and 2002 under a 5% cap. (Their loss would be about $13 billion if payments grew at the national average rate of growth).
  - Some states with low growth rates would actually benefit from a block grant. For example, Colorado would gain over $700 million between 1996 and 2002 under a block grant with a 5% cap if it could sustain its recent growth rates..

Illustrative Effect of a Medicaid Block Grant
Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002
(Dollars in millions, fiscal years)

	State Baseline Growth at National Rates	State Baseline Growth at State Projected Rates
US	**(192,119)**	**(172,965)**
Alabama	(2,772)	(709)
Alaska	(368)	217
Arizona	(2,531)	(3,364)
Arkansas	(1,839)	(156)
California	(21,125)	(5,075)
Colorado	(1,701)	714
Connecticut	(2,742)	(3,342)
Delaware	(377)	(261)
District of Columbia	(896)	(1,484)
Florida	(7,645)	(13,483)
Georgia	(4,766)	(6,231)
Hawaii	(584)	(864)
Idaho	(529)	(439)
Illinois	(6,476)	(3,477)
Indiana	(3,936)	1,979
Iowa	(1,594)	(1,138)
Kansas	(1,238)	1,093
Kentucky	(2,901)	50
Louisiana	(6,295)	373
Maine	(1,299)	(299)
Maryland	(2,944)	(4,932)
Massachusetts	(5,052)	(2,655)
Michigan	(6,549)	(4,829)
Minnesota	(3,236)	(4,071)
Mississippi	(2,396)	(1,695)
Missouri	(3,469)	(1,706)
Montana	(538)	(163)
Nebraska	(903)	(1,014)
Nevada	(470)	110
New Hampshire	(740)	(879)
New Jersey	(5,313)	1,941
New Mexico	(1,173)	(1,888)
New York	(27,160)	(65,988)
North Carolina	(5,062)	(8,653)
North Dakota	(425)	27
Ohio	(7,988)	(7,167)
Oklahoma	(1,691)	271
Oregon	(1,861)	(4,940)
Pennsylvania	(8,875)	1,437
Rhode Island	(1,006)	549
South Carolina	(3,176)	289
South Dakota	(481)	(541)
Tennessee	(5,019)	(2,459)
Texas	(12,688)	(20,865)
Utah	(914)	(862)
Vermont	(413)	(183)
Virginia	(2,263)	(1,158)
Washington	(3,368)	(3,576)
West Virginia	(1,979)	(284)
Wisconsin	(3,120)	(942)
Wyoming	(237)	(246)

Assumes that Federal payments to states grow at the CBO projected national average growth rates (column 1) or each state's average compound growth rate between FY 1993 (actual data) and states' projected expenditures for FY 1996 (column 2). The states submitted these projected expenditures in November, 1994.

POTENTIAL STATE RESPONSES TO OFFSET FEDERAL PAYMENT REDUCTIONS

- Medicaid Managed Care
- Reduction in Payments to Providers
- Reduction in Benefits
- Reduction in Eligibility/Recipients
- Increase or Decrease in State Medicaid Spending

MEDICAID MANAGED CARE

- While many point to managed care as a source of significant savings under Medicaid, studies (including one by CBO) have generally found that it produces a one-time savings of about 5 to 15% over baseline costs without slowing the rate of growth.

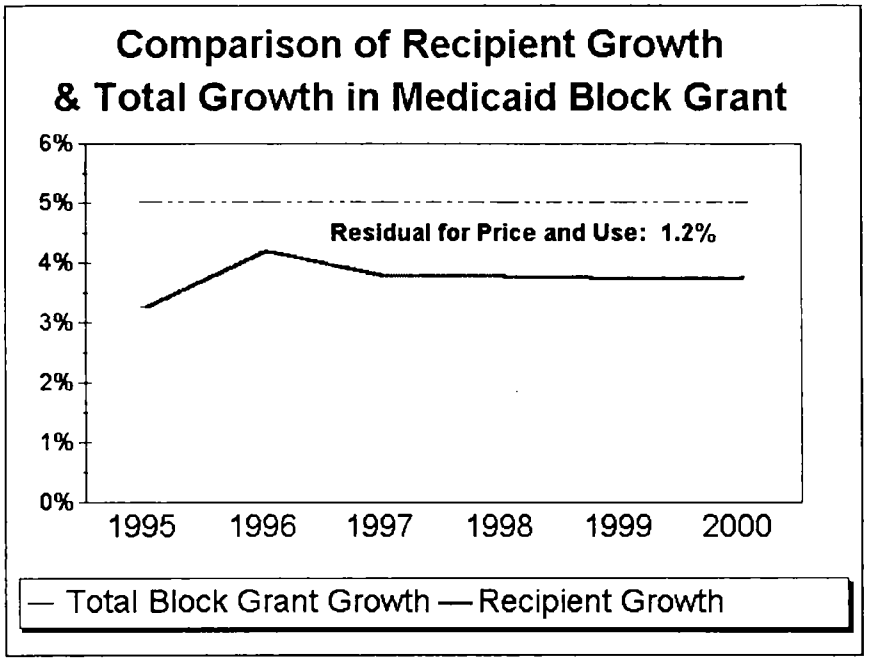
- States have applied managed care primarily to children and AFDC adults, who account for less than one-third of Medicaid spending. Applying managed care techniques to the services typically used by the elderly and disabled (such as long term care) is largely untried and difficult, making the potential for achieving savings hard to predict.

- Baseline projections already assume that a substantial proportion of Medicaid recipients will be in managed care arrangements (33% of AFDC and non-cash children currently, growing to over 50% by the end of the decade).

- Therefore, the percentage of Medicaid spending for which there is some evidence that managed care could produce saving is relatively small, and varies significantly by state (e.g., the percentage of state Medicaid enrollees that are aged or disabled ranges from 15% to 40%).

- Preliminary estimates show that if **all** AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be less than $4 billion, a very small proportion of the $309 billion (under Administration baseline) needed to offset the reduction in federal payments over this period.

BASELINE ENROLLMENT GROWTH



- The number of people covered by Medicaid is projected to grow by an average of 3.8% a year from 1996 to 2000.

- If states did not reduce coverage under Medicaid, a block grant growing at 5% per year would allow only 1.2% growth in federal Medicaid payments per person. This is far less than the 5.3% projected annual growth in medical inflation.

REDUCTIONS IN PROVIDERS PAYMENTS, BENEFITS AND ELIGIBILITY

Because managed care cannot produce anywhere near the level of necessary savings, states would be forced to respond by reducing payments to providers, cutting benefits or cutting eligibility. The following **illustrates** the magnitude of the cuts necessary to offset the reduction in federal payments.

- If states chose to respond by cutting provider payments only:
  - In 1997, a 4% reduction in provider payments would be needed.
  - In 2002, a 14% reduction would be needed.
  - In 2005, a 19% reduction would be needed.

- If states chose to respond by reducing benefits only:
  - In 1997, eliminating home health, hospice, and assistance for Medicare premiums and cost sharing would offset the reduction.
  - In 2002, however, eliminating these benefits would achieve only about one-third of the necessary savings.
  - Eliminating home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services would offset the federal reduction in payments.

- If states chose to respond by cutting back on eligibility only:
  - In 1997, eliminating eligibility for non-cash children (the OBRA expansions) would almost achieve the savings necessary.
  - In 2002, however, eliminating eligibility for this population would offset less than one-third of the reduction in federal payments, and eliminate coverage for over 6 million children.
  - Eliminating eligibility for both non-cash kids and AFDC adults would offset about 80% of the reduction in federal payments and would eliminate 11 million people from Medicaid.

COMBINATION OF MEDICAID SERVICE, PROVIDER, AND RECIPIENT CUTS

- A state could react to the reduced federal Medicaid payments by combining Medicaid managed care, benefits reductions, provider payment reductions and recipient cuts.

- The following scenario illustrates one way that states could offset the federal Medicaid cut in payments of **$39.4 billion** in 2002.

  - Enrolling all adults and children through Medicaid managed care would reduce costs by about $1 billion.

  - Eliminating home health, personal care services and premium and cost-sharing support for Medicare dual eligibles would reduce costs by $17.4 billion.

  - A 5% across-the-board reduction in provider payments would reduce costs by $11.5 billion.

  - Cutting eligibility for a little over 4 million non-disabled adults and children would reduce costs by $9.5 billion.

CAPPING MEDICARE SPENDING

- Republican efforts to balance the federal budget may also lead to proposals to cap federal spending for the Medicare program. For example, Senator Dole has suggested a reduction in Medicare spending of about $150 billion between 1996 and 2000. This is approximately equivalent to capping annual growth in Medicare spending at about 5% beginning in 1996.

- Medicare is currently projected to grow at an average annual rate of 9.3% between fiscal years 1996 and 2002 (9.8% under CBO baseline).

  On a per person basis, Medicare actually is projected to grow at about the same rate (about 7.6% as compared to 7.8%) as private health spending for people with insurance. (Under CBO projections, per capita Medicare expenditures may be growing at a slightly faster rate than private health spending).

- Using CBO budget estimates, a 5% growth cap would reduce federal Medicare spending below baseline projections by almost $328 billion from fiscal years 1996 to 2002, and by $720 billion from 1996 to 2005.

- The following table shows the potential effects of a 5% growth cap on a state-by-state basis. This analysis assumes that Medicare spending in each state under the status quo would grow at same rate as CBO projects overall Medicare spending to grow.

Illustrative Effect of Medicare Capped Expenditures
Reduction in Federal Payments Assuming 5% Growth Cap
(Dollars in millions, fiscal years)

	1996 - 2002
US*	(328,328)
Alabama	(5,647)
Alaska	(223)
Arizona	(4,999)
Arkansas	(2,997)
California	(37,838)
Colorado	(3,281)
Connecticut	(4,711)
Delaware	(822)
District of Columbia	(2,552)
Florida	(26,901)
Georgia	(7,577)
Hawaii	(1,085)
Idaho	(784)
Illinois	(14,083)
Indiana	(6,599)
Iowa	(2,996)
Kansas	(3,099)
Kentucky	(4,495)
Louisiana	(5,983)
Maine	(1,289)
Maryland	(5,668)
Massachusetts	(10,298)
Michigan	(11,868)
Minnesota	(4,834)
Mississippi	(3,047)
Missouri	(7,165)
Montana	(848)
Nebraska	(1,582)
Nevada	(1,523)
New Hampshire	(1,061)
New Jersey	(10,899)
New Mexico	(1,277)
New York	(26,272)
North Carolina	(7,441)
North Dakota	(797)
Ohio	(13,967)
Oklahoma	(3,549)
Oregon	(3,313)
Pennsylvania	(21,276)
Rhode Island	(1,443)
South Carolina	(3,305)
South Dakota	(761)
Tennessee	(7,462)
Texas	(18,376)
Utah	(1,356)
Vermont	(523)
Virginia	(5,554)
Washington	(4,972)
West Virginia	(2,334)
Wisconsin	(5,290)
Wyoming	(315)

Federal payment reductions are allocated across states in proportion to the states' FY 1993 share of Medicare spending.

* States' losses do not sum to U.S. losses due to the exclusion of territories.

POTENTIAL RESPONSES TO ACCOMPLISH REDUCED MEDICARE SPENDING GROWTH

- Medicare Managed Care
- Reduction in Medicare Payments to Providers
- Reduction in Medicare Benefits
- Increases in Medicare Premiums

MEDICARE MANAGED CARE

The potential for achieving scorable savings in Medicare through managed care is uncertain.

- Currently, 74 % of Medicare beneficiaries have access to a managed care option and 9% of Medicare beneficiaries have chosen to enroll in a managed care plan. Of this 9%, two-thirds are enrolled in an HMO. By the year 2000, we project that about 16% of beneficiaries will be enrolled in HMOs.

- Managed care currently costs the Medicare program rather than achieving savings. Evaluations have determined that due to favorable selection, Medicare pays 5.7% more for every enrollee in risk-based managed care than would have been paid if the beneficiary had stayed in fee-for-service.

- CBO has testified that expanding enrollment in managed care plans under the current system would be unlikely to reduce federal costs, and that the changes that would be necessary to the current payment system for managed care would be "difficult to specify."

- The Department has a number of efforts underway to improve and expand the managed care choices available to beneficiaries, including developing a PPO option and evaluating methods to improve the current payment methodology for Medicare managed care plans.

COMBINATION OF REDUCED PAYMENTS TO PROVIDERS AND BENEFICIARY PREMIUM INCREASES

- Under the Mainstream Coalition bill, Medicare cuts were distributed across providers and beneficiaries so that providers bore about three-quarters of the reductions and beneficiaries bore about one-quarter. Using this same distribution, the following would be necessary to offset the effects of a 5% cap on Medicare.

- **Provider Cuts**:

Hospitals:	9% reduction in 1997; 26% reduction in 2002; and 39% reduction in 2005.
Physicians:	8% reduction in 1997; 22% reduction in 2002; and 28% reduction in 2005.
Other Providers:	6% reduction in 1997; 13% reduction in 2002; and 16% reduction in 2005.

  - A relatively large percentage of rural hospitals are heavily dependent on Medicare as a source of revenue. Rural hospitals also are more likely to have negative Medicare margins than urban hospitals.

- **Increases in Medicare Premiums**: If these savings were achieved by increasing Medicare premiums, the premiums would increase by:

  $142 per year in 1997;
  $533 per year in 2002; and
  $898 per year in 2005.

  - Medicare beneficiaries already spend almost 12% of their household incomes on health care, as compared to less than 4% for nonelderly families.

EFFECTS ON ACCESS AND PRIVATE PAYERS

- Between 1996 and 2002, 5% caps on the growth in Medicaid and Medicare would reduce federal health payments by over $500 billion.

- Reductions of this magnitude raises questions about how providers would respond. With the number of uninsured projected to rise over the decade, hospitals and other providers will be face the strain of provider more uncompensated care with fewer resources. Cuts in Medicaid enrollment would exacerbate the strain.

- Recently, it appears that private payers – particularly large employers – have intensified their cost containment efforts. These efforts have forced hospitals and other providers to reduce expenses, further diminishing their capacity to absorb reductions in Medicare and Medicaid payments and increases in uncompensated care.

- Given the magnitude of the proposed cuts, providers may not be able to respond to the reductions in payments entirely through increased efficiency.

    - Access to care for Medicare beneficiaries and uninsured patients may be jeopardized. Understandably, providers may be less willing to see these patients as their sources of payment shrink.

    - Private payers may also bear a portion of this burden through cost shifting. Small employers and individual purchasers, who have less leverage in the marketplace, may be particularly vulnerable to cost shifting.

Illustrative Effect of a Medicaid Block Grant & Medicare Capped Expenditures Reduction in Federal Payments Assuming 5% Growth Cap: 1996 - 2002
(Dollars in millions, fiscal years)

	State Baseline Growth at National Rates	State Baseline Growth at State Projected Rates
US	**(520,447)**	**(501,293)**
Alabama	(8,419)	(6,356)
Alaska	(591)	(6)
Arizona	(7,530)	(8,363)
Arkansas	(4,836)	(3,154)
California	(58,963)	(42,913)
Colorado	(4,981)	(2,567)
Connecticut	(7,452)	(8,053)
Delaware	(1,199)	(1,084)
District of Columbia	(3,447)	(4,036)
Florida	(34,546)	(40,384)
Georgia	(12,343)	(13,808)
Hawaii	(1,669)	(1,948)
Idaho	(1,313)	(1,223)
Illinois	(20,559)	(17,560)
Indiana	(10,536)	(4,620)
Iowa	(4,590)	(4,133)
Kansas	(4,336)	(2,005)
Kentucky	(7,396)	(4,446)
Louisiana	(12,278)	(5,610)
Maine	(2,588)	(1,588)
Maryland	(8,611)	(10,600)
Massachusetts	(15,349)	(12,952)
Michigan	(18,417)	(16,697)
Minnesota	(8,069)	(8,905)
Mississippi	(5,444)	(4,743)
Missouri	(10,634)	(8,871)
Montana	(1,386)	(1,011)
Nebraska	(2,486)	(2,596)
Nevada	(1,993)	(1,413)
New Hampshire	(1,801)	(1,940)
New Jersey	(16,213)	(8,958)
New Mexico	(2,450)	(3,166)
New York	(53,432)	(92,260)
North Carolina	(12,503)	(16,093)
North Dakota	(1,221)	(770)
Ohio	(21,955)	(21,134)
Oklahoma	(5,240)	(3,278)
Oregon	(5,174)	(8,253)
Pennsylvania	(30,151)	(19,839)
Rhode Island	(2,449)	(894)
South Carolina	(6,482)	(3,016)
South Dakota	(1,242)	(1,301)
Tennessee	(12,481)	(9,921)
Texas	(31,063)	(39,241)
Utah	(2,270)	(2,218)
Vermont	(936)	(706)
Virginia	(7,817)	(6,712)
Washington	(8,340)	(8,548)
West Virginia	(4,313)	(2,618)
Wisconsin	(8,410)	(6,232)
Wyoming	(555)	(564)

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.

Assumes that Federal Medicare and Medicaid payments grow at the CBO projected national average growth rates (column 1) or the Medicaid average compound growth rates between FY 1993 (actual data) and states' projected expenditures for each state for FY 1995 (column 2).