Different Paths, Same Goal: End Medicaid as We Know It

By Rachel Benson Gold

Since its arrival in Washington, the Bush administration has been open about its desire to restructure and, in the process, sharply reduce benefit guarantees under Medicaid—the nation's central safety-net health care program for the poor and a critical funder of reproductive health services for low-income women. Rebuffed last year in its attempt to do so directly, through legislation converting the program into a block grant to the states, the administration has since turned to various backdoor approaches. While these approaches are generating opposition as well, the fact remains that calls for program cutbacks under the rubric of Medicaid "reform" are likely to be heard for a long time to come.

At the heart of the debate is Medicaid's status as an individual "entitlement" program—one in which any person meeting the program's eligibility requirements is legally entitled to enroll. Because of that fundamental organizing principal, Medicaid expenditures, which are shared by the federal government and the states, are not directly controlled by Congress and state legislatures, or even totally predictable. Instead, they rise and fall more or less automatically with the number of program enrollees—itself largely a function of overall economic conditions. Soaring enrollment during a prolonged period of national economic stagnation—while entirely expected given the basic design of the program—have nonetheless made Medicaid a major financial burden for the states in recent years ("States Eye Medicaid Cuts as Cure for Fiscal Woes," *TGR,* August 2003, page 6).

If at First You Don't Succeed…

In 2003, the Bush administration made the cash-strapped states an offer it apparently felt they could not refuse. Taking on the individual entitlement to Medicaid directly, it proffered a legislative proposal to convert the program into a "capped block grant," under which each state would be provided a fixed annual allotment of Medicaid dollars. In return, the states would be given considerably more flexibility than they have under the current Medicaid statute to determine both the populations they would cover and the scope of benefits that would be provided.

Clearly expecting that the states—which had long sought more flexibility in designing their programs—would welcome the initiative, the administration seemed caught off guard by the tepid response it received; many governors, upon reading the fine print, were unwilling to trade flexibility for a cap on federal expenditures. After meeting several times, a task force assembled by the National Governors Association to consider the administration's proposal disbanded without securing an agreement, effectively ending the administration's effort for the year.

This year, the administration abandoned its straightforward legislative approach, seeking instead to achieve its goals through the back door. To date, it has pursued two different strategies. The first was through a proposal put forward as a simple revision in data-collection processes. In January, the Centers for Medicare and Medicaid Services (CMS) proposed to revise a form states currently use to estimate anticipated Medicaid expenditures. Under the proposal, states would be required to provide additional detail about expected expenditures and, more significantly, would then be allowed to exceed that level only with federal permission—a move that effectively would have established a ceiling for program costs. While CMS characterized the proposed change as nothing more than a revision to a data-collection form, it simultaneously stated that the need for the revision was sufficiently urgent to justify only a one-day public comment period.

The administration is turning to backdoor approaches to convert the program into a block grant.

Once again, however, states gave the administration's proposal a less-than-enthusiastic welcome. After protests from governors of both parties, the administration announced it would reconsider the proposed revisions in consultation with the states. A CMS-assembled task force of state Medicaid directors reportedly met once, and nothing has been heard on revising the CMS form since.

…Try and Try Again

The administration's second strategy was unveiled in its FY 2005 budget request in February. The budget underscored the administration's backdoor approach by neither including a line item for a Medicaid block grant nor announcing a legislative proposal. Instead, the budget signaled the administration's willingness to negotiate with individual states to allow them to receive pro-

Medicaid's Critical Importance to Family Planning Services for Low-Income Women

Medicaid is the nation's largest health care program. More than one in 10 women of reproductive age—and more than one in three poor women of reproductive age—rely on the program for their health care. Medicaid is also critically important to the delivery of subsidized family planning services in the United States.

Medicaid is the single largest source of public dollars for family planning.

• Together, the federal and state governments spent $770 million to provide family planning services under the Medicaid program in 2001.

• One-third of all women of reproductive age enrolled in Medicaid obtained a Medicaid-covered family planning service in 1998.

• One in four clients receiving services through publicly funded family planning clinics have their care paid for by Medicaid.

Family planning has long had a special status within Medicaid.

• Family planning is one of a small number of services that federal law requires all state Medicaid programs to cover, giving Medicaid enrollees nationwide a legal entitlement to family planning services and supplies.

• To encourage states to make family planning widely available to Medicaid enrollees, federal law provides a special federal matching rate of 90% for family planning services and supplies. This is significantly higher than the federal match for most other services, which ranges from 50–77%, depending on the wealth of the state.

• Medicaid enrollees may not be required to pay any out-of-pocket costs for family planning, even though they may face charges for most other services.

• In most cases, Medicaid enrollees may obtain family planning from the provider of their choice, even if that provider is not affiliated with their managed care plan.

Over the last decade, 18 states have obtained federal approval to expand eligibility for Medicaid-covered family planning services to various groups of women (and in some states, men) not eligible for regular Medicaid coverage. In 2001, these programs served at least 1.7 million people, 1.3 million in California alone. A recent evaluation of these efforts, funded by CMS, found that all six of the programs studied resulted in significant savings to both the federal and state governments. Moreover, the researchers found evidence in these programs of improved geographic availability of services, expanded diversity of family planning providers and measurable reductions in unintended pregnancy.

For more information on the importance of Medicaid to family planning, see "Medicaid: A Critical Source of Support for Family Planning in the United States," a joint Issue Brief from The Alan Guttmacher Institute and the Kaiser Family Foundation, available at <http://www.guttmacher.org/pubs/medicaid050304.html>.

gram funding "in the form of flexible allotments." For Medicaid advocacy organizations such as Families USA, the administration was simply proposing state block grants by another name. "The language used in the text of the [budget] documents makes it quite clear that the Administration has not backed away from its ideological support of the [block grant] proposal nor diminished its interest in seeing a block grant proposal move forward," said Deputy Director of Government Affairs Lena O'Rourke in her analysis of the budget proposal.

In mid-February, New Hampshire Gov. Craig Benson (R) announced that he intended to ask Department of Health and Human Services Secretary Tommy G. Thompson to make his state the first to test a block grant program. Since then, Republican governors in three additional states—California, Connecticut and Florida—have indicated they are considering applying for waivers, often in return for accepting a fixed cap in federal Medicaid allotments. Federal law would continue to require coverage of a limited set of federally mandated benefits (including family planning) to some federally mandated groups of enrollees. However, under the waivers, states would have virtually unlimited control over the benefits provided to any additional enrollees, or even whether to cover them at all.

Interestingly, the legislatures in two of these states viewed the notion of a Medicaid block grant with considerably greater skepticism than did their governors. In May, the Democratic-controlled Connecticut legislature put an end, at least for this year, to waiver negotiations by adding language to the state budget expressly prohibiting an agreement that would limit the "normal" federal contribution to Medicaid. Meanwhile, in New Hampshire, the Republican-controlled legislature added language to the state's budget requiring the governor to obtain its approval before actually applying for a waiver. After passing the budget, the legislature promptly adjourned,

effectively blocking any waiver submission until the biennial legislature returns in 2006.

Nonetheless, waivers are still very much on the table in the two other states. In California, where state law requires legislative approval of a waiver application, Gov. Arnold Schwarzenegger has promised to detail a plan to restructure Medicaid for the legislature in August. Although the governor has indicated that he hopes to receive the legislature's approval by the end of the year, he also has vowed to move forward and submit a waiver application in the fall even in the absence of approval, in which case he would come back and seek the legislature's assent next year.

That a radical overhaul is necessary to address the burden Medicaid currently is placing on state budgets is by no means universally acknowledged.

In Florida, meanwhile, Gov. Jeb Bush also is pushing for a block grant in the face of unexpectedly strong opposition from health care providers, who are generally among his most loyal allies. In March, the state medical association joined with 63 other organizations to express concern about the effort. According to media accounts, the critical state affiliate of the American Association of Retired Persons also voiced its opposition. While Gov. Bush has responded by promising more "sunshine" through the process of developing a waiver, advocates are expecting a proposal to be submitted this fall.

The Debate Continues

For women in need of reproductive health care, the stakes in the debate over Medicaid's future could not be higher. More than one in three low-income women of reproductive age depends on the program for her health care. Medicaid pays for nearly one in four births in the United States each year. And with family planning one of a handful of required services in the Medicaid basic benefits package, the program is the largest funder of subsidized family planning services and supplies nationwide (see box, page 5).

In June, Sens. Chuck Grassley (R-IA) and Max Baucus (D-MT), the powerful chair and ranking member of the Senate Finance Committee, which has jurisdiction over Medicaid, entered the fray. The two key senators sent a joint letter to CMS Administrator Mark McClellan, reminding him that at his confirmation hearings earlier this year he had specifically agreed with them that an entitlement "cannot be waived." The letter expressed the senators' concern "about reports describing active but private negotiations between CMS and several states on waiver programs that would cap enrollment and/or federal payments." The two senators have asked McClellan for a full briefing on the status of waiver negotiations.

Resistance to block-granting Medicaid demonstrated to date at both the state and federal levels virtually ensures that the administration will not fully achieve its goals this year. Still, with Medicaid expenditures now accounting for some 20% of total state expenditures, the extent to which it is draining state coffers is considerable. "It is the Pac-Man of the budget," Ken Pruitt (R), chair of the Appropriations Committee of the Florida Senate was quoted recently in the *Sarasota Herald-Tribune* as saying. "There is absolutely no way that we can remain fiscally viable and meet the needs of this state while Medicaid is on an absolute rampage, eating us alive financially."

That a radical overhaul is necessary to address the burden Medicaid currently is placing on state budgets is by no means universally acknowledged. Program supporters argue that Medicaid is doing exactly what it was designed to do—expand during difficult economic times to meet the increased need. Last year, Congress provided temporary fiscal relief to assist the states in shouldering this burden. With that funding having run out in June, Sens. Jay Rockefeller (D-WV) and Gordon H. Smith (R-OR) are trying to extend that federal aid until states have completely weathered the economic storm. While the economy is improving, said Smith, "it has not yet fully recovered. So more must be done to protect the programs that people turn to when they are in need, programs like Medicaid."

Still, the Bush administration remains committed to "solving" Medicaid's problems by discarding the individual entitlement to coverage that is at the program's core. So do many other conservative policymakers in Washington and the states. While the future of Medicaid in no small measure may be riding on the outcome of the November elections, then, the debate in one form or another almost certainly will continue.