

Key Findings

1. Washington is faced with the choice of opting-out of Medicaid or eliminating state only health care programs.
2. Restrictions in the new federal health care law are limiting state policymakers' options to balance the budget.
3. To avoid radical disruptions to state health care networks, Congress should transform the Medicaid program into an indexed block grant.
4. Without reform states will merely be passive administrators of the federal Medicaid program while state-only health care programs are eliminated to balance budgets.

Washington Needs Medicaid Flexibility

by Roger Stark, MD, FACS, Health Care Policy Analyst
Jason Mercier, Director, Center for Government Reform

December 2010

Introduction

Earlier this year Washington State officials debated the possibility of opting-out of the federal Medicaid program in order to preserve flexibility in providing health care services to needy families in Washington. As it currently stands, Washington faces a nearly a \$6 billion projected budget shortfall. The alternative to opting-out of Medicaid is the potential elimination of all state-only health care programs such as the Basic Health Plan, prescription drug coverage, and the disability lifeline.

The new federal health care law imposes a Medicaid Maintenance of Eligibility restriction on the states. According to the new law:

“... a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.”¹

This restriction, combined with looming budget deficits means Washington legislators can either fund state-only health programs or provide matching funds for federal Medicaid dollars – they cannot do both. This debate is not unique to Washington and is occurring across the country including in Texas. Already health officials in Nevada and Wyoming have drafted white papers discussing the possibility of opting-out of Medicaid to provide more budget flexibility.²

We recently surveyed state Medicaid directors across the country to see whether they were also discussing opting-out of Medicaid. Among the responses we received was this one from Carol Steckel, Commissioner of Alabama's Medicaid Agency:

“We have not specifically discussed this issue with the Governor. However, we [are] about to be transitioning to a new Governor (January 17th). That may be an option he wants to consider. I definitely think that if HHS pushes an expansive definition of the health benefits package and continues to expand in other areas, many states, including Alabama will have no

¹ H.R. 3590 “The Patient Protection and Affordable Care Act”, Sec. 2001 (2010) at <http://thomas.loc.gov/cgi-bin/query/F?c111:1:./temp/~c111vPvMDB:e484967>:

² “Medicaid Opt Out,” Nevada Department of Health and Human Services and the Division of Health Care Financing and Policy, January 22, 2010 at <http://media.lasvegassun.com/media/pdfs/blogs/documents/2010/01/28/medicaid0128.pdf> and “Medicaid Opt-Out Impact Analysis,” Wyoming Department of Health, September 1, 2010 at <http://www.health.wyo.gov/Media.aspx?mediaId=9664>

other choice. If it goes too far, states will have to choose between Medicaid and ALL other general fund services!”³

Washington State’s Medicaid Dilemma

Throughout the fall Washington Policy Center has been participating as a member of Governor Gregoire’s Budget Transformation Committee. One of the problems quickly identified concerning health care spending was the crowding out of state-only programs as a result of the federal restrictions on Medicaid spending.

According to the state’s Medicaid Director, Doug Porter, Washington is out of options:

“Given the targets I have to reduce expenditures in the current fiscal year (\$113M general fund state) and over the next biennium (\$521M), I cannot see how Washington can afford to support both the Medicaid program and our state-only programs, such as Disability Lifeline and the Basic Health program.”⁴

Though Washington opting-out of Medicaid remains unlikely, the fact that it is openly discussed signifies the need for states to have more flexibility in the Medicaid program. Otherwise state health care spending will be limited to administering the federal Medicaid program at the expense of state-directed priorities.

One possibility is for Congress to move away from the Medicaid spending categories dictated by federal officials and to transform the federal program into an indexed block grant that would allow each state to design its own program to meet the needs of its citizens.

What is Medicaid?

The Medicaid program began in 1965 with the passage of Title XIX of the Social Security Act. It has always been an entitlement, with no defined limit on the number of beneficiaries or the cost of the program. As long as a person meets the legal criteria for participation in the program, that person receives Medicaid benefits, regardless of total cost to taxpayers.

From the beginning a link was established between Medicaid eligibility and the welfare program, Aid to Families with Dependant Children (AFDC).⁵ Medicaid is now the largest health insurance system in the United States and is the largest means-tested health care program in the world.

The cost of Medicaid is shared between federal and state governments. Each state receives federal money on a sliding scale based on average personal income, with poorer states getting a higher percentage of federal funds. At present, the average match for Medicaid spending is 57 percent in federal money and 43 percent in state funds.⁶ Medicaid spending is now the fastest growing line item in

³ E-mail communication with Carol H. Steckel, Commissioner, Alabama Medicaid Agency, October 13, 2010, copy available on request.

⁴ E-mail communication with Doug Porter, Medicaid Director, Washington Health Care Authority, October 22, 2010, copy available on request.

⁵ “Medicaid Legislative History, 1965-2000”, The Kaiser Commission on Medicaid and the Uninsured, Appendix 1, p 175, 2000.

⁶ “Brief Summaries of Medicare and Medicaid,” by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department on Health and Human Services, November 1, 2008.

virtually every state in the country. In 2006, Medicaid spending accounted for 23 percent of the average state budget.⁷

Medicaid spending is now the fastest growing line item in nearly every state in the country. In 2008, Medicaid spending accounted for 21 percent of the average state budget and 20 percent in Washington state.⁸ Total spending on Medicaid in Washington State was \$6.3 billion for fiscal 2008.⁹ The contribution from Washington State taxpayers was 48 percent of the total which is higher than the national average of 43 percent.

The Impact of the New Medicaid Program on Washington State

The new federal health care law will greatly expand Medicaid starting in 2014. This new Medicaid program will provide health insurance to anyone in the country who earns less than 133 percent of the Federal Poverty Level (FPL) and is under the age of 65. The FPL is currently \$10,830, so anyone making less than \$14,400 annually will be eligible.

Overall costs of the Medicaid expansion are estimated to be \$445 billion from federal taxpayers and \$21 billion from state taxpayers between 2014 and 2019. This \$466 billion represents approximately one half of the overall costs of the federal law.

No one knows the exact number of new Medicaid enrollees because of the complexity of the new law. There are currently 60 million people enrolled in Medicaid nationally, which means Washington state's 1.2 million people represent 2 percent of the total. Estimates (and they are just that) of new enrollees range from 14 to 23 million. Hence 2 percent would be 280,000 to 460,000 people in Washington State.

Washington state currently has 1.2 million people in its Medicaid program at a total cost to state taxpayers of \$3.1 billion (this is matched by \$3.1 billion of federal money) per year. This works out to approximately \$2,583 of state taxpayer dollars per recipient and a total cost (federal plus state) of \$5,167 per enrollee.

The new health care law is written so that federal taxpayers cover the entire cost of the new Medicaid patients for the first three years and states ultimately pay 10 percent of the costs. Washington state taxpayers would therefore be required to pay \$5,167 times 10 percent times 280,000 (or 460,000) per year which equals \$145 million (or \$242 million). For a ten year period, Washington State taxpayers would be obligated to pay \$1.45 billion to \$2.42 billion in new Medicaid spending.

If the state/federal ratio for funding new Medicaid patients reverts to the fifty-fifty split as it exists now, Washington taxpayers will be required to pay \$5,167 times 50 percent times 280,000 (or 460,000). This would equal \$723 million (or \$1.2 billion) per year, and \$7.23 billion (or \$12 billion) every ten years. Of course, state taxpayers are also federal taxpayers, so Washington state taxpayers will be required to help pay the entire cost of Medicaid expansion, or \$14.5 billion to \$24 billion over a ten-year period.

It is a combination of these long term-costs and the short-term challenges that are leading state officials to debate opting-out of the Medicaid program entirely.

⁷ "2005 State Expenditure Report," National Association of State Budget Officers, November 2006, pages 2-3.

⁸ <http://www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx>

⁹ <http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=49>

Policy Recommendation: Restructure Medicaid as an Indexed Block Grant Program

To help provide state officials with the necessary flexibility, Medicaid should be restructured as an indexed block grant program. An indexed block grant would allow state Medicaid funds to grow each year based on a national fiscal growth factor.

An indexed Medicaid block grant would also provide Washington state the flexibility to set up one state-controlled health insurance program to cover all patients who now qualify for Medicaid, Basic Health and the Children's Health Insurance Program. Expenses could be controlled by capping the amount of spending each enrollee could receive.

The best solution for containing costs would be to give Medicaid patients control of those health insurance dollars. The state could allow a voucher program to cover out-of-pocket health expenses through health savings accounts (HSAs) and allow insurance companies to offer true catastrophic insurance plans for Medicaid patients.

This would eliminate the third-party payer system and would incentivize enrollees to manage their health care dollars carefully and to seek only necessary care. Indiana and, to a lesser extent, Florida have successful programs in place using vouchers, HSAs and catastrophic plans.

A less desirable, but popular, alternative in a capitated environment would be to place patients in a health maintenance organization (HMO) with fixed provider reimbursement. HMOs have experienced varying levels of popularity since the 1970s. They have limited patient and provider satisfaction and have limited access to health care for thousands of patients because of the fixed reimbursements.

Conclusion

Unless states are provided more flexibility over Medicaid spending they will be forced to either opt-out of the program or eliminate state-only health care priorities. A better strategy would be for Congress to pass a bill that transforms the current categorically restricted Medicaid program, dictated by D.C. priorities, into an indexed block grant program that would allow each state to design a comprehensive state-based health care system that meets the unique needs and priorities of their citizens.

To help determine what indexed growth factor should be used for a Medicaid block grant program, the National Governors Association and the National Association of State Medicaid Directors should work to design a growth factor that would meet state needs, as well as help to provide predictability of federal Medicaid exposure to help with deficit reduction efforts.

To avoid radical disruptions to state health care networks, Congress should transform the Medicaid program into an indexed block grant program. Failure to do so will result in states merely becoming passive administrators of the federal Medicaid program while state-only health care programs are eliminated to balance budgets. Reforming Medicaid into a block grant that provides state spending flexibility will instead facilitate fifty laboratories of democracy working to identify innovative health care reforms.

Dr. Roger Stark is a retired surgeon and a Health Care Policy Analyst with Washington Policy Center. Jason Mercier is Director of WPC's Center for Government Reform. WPC is a non-partisan independent policy research organization in Washington state.