

Gail R. Wilensky

## the challenges of Medicaid

Between the president's focus on Social Security and the release of the latest Medicare Trustees report this spring, most of the media's attention has been focused on these two federal programs. But it is Medicaid that is presenting the more immediate challenge for both the current federal budget and the states.

The federal-state Medicaid program currently provides acute care and long-term care services to some 53 million people. The total spending for Medicaid in 2003 was \$277 billion, \$162 billion from the federal government and \$115 billion from the states. The federal share alone grew from \$129 billion in 2001 to an expected \$193 billion for 2006, an average annual increase of 8.3 percent. In the past two years, total Medicaid outlays grew slightly faster, between 9 percent and 10 percent. The Congressional Budget Office projects that Medicaid will grow at an average rate of 8.7 percent for the next decade, bringing the federal share of Medicaid to \$392 billion by 2015.

### Federal Solutions: Past Efforts

Medicaid received relatively little attention during the first Bush term, although some change was attempted and additional flexibility was introduced through the Health Insurance Flexibility and Accountability demonstration initiative. Under HIFA, the Department of Health and Human Services waived certain federal requirements and issued 17 comprehensive waivers that allowed states to expand their eligible populations and change the benefit structure for their enrollees.

In 2003, the administration proposed capping federal spending on "optional" Medicaid populations, including nursing home patients and certain low-income pregnant women and children. Under the proposal, states could have chosen capped increases in federal outlays each year for their optional populations in return for receiving more federal money up front. Not surprisingly, neither Congress nor the governors showed much interest in the proposal, and it never went anywhere legislatively.

### Federal Solutions: Current Proposals

The administration's current budget proposed \$60 billion of savings from Medicaid over 10 years and \$14 billion over five years. Although most of the savings came from closing some of the "creative financing" strategies that states were using to collect extra federal dollars without increasing their own state share—strategies that included changing how pharmaceuticals were reimbursed and tightening asset transfer rules used to determine Medicaid eligibility for nursing homes—the proposal drew immediate bipartisan opposition from the governors.

Congress has been struggling with getting a budget out of conference that resolves the many differences between the House and Senate budget bills, including differences for Medicaid. The House bill approved reductions in Medicaid spending of \$15 billion to \$20 billion over the next decade, but the Senate voted against any reductions in Medicaid.

The budget resolution approved at the end of April included a \$10 billion reduction in Medicaid funding over five years. It also included a provision by Sen. Gordon Smith (R-Ore.) to create a bipartisan commission that would find ways to reduce fraud and abuse in the state-reimbursement component of Medicaid and make other reductions in Medicaid that would not undermine the states' abilities to provide services. Although the budget resolution is nonbinding, it sets guidelines for Congress as it begins deliberating about FY06 spending decisions.

### An Ongoing Challenge

The larger issue of what to do about Medicaid remains unanswered. Medicaid has expanded its domain of coverage over the years, from a program initially focusing on single mothers with children and individuals on welfare to today's program providing healthcare coverage for low-income mothers and children, acute care and long-term care for the elderly and disabled, and wraparound insurance coverage for the poor elderly. Only a minority of those now on Medicaid actually receive cash assistance programs.

As much as Medicaid has become a challenge for the federal government, it has become even more troublesome to state governments. The past two to three years have been particularly challenging to the states because the substantial increases in Medicaid spending have coincided with unprecedented declines in state revenue, with the result that the states have found themselves desperate to reduce spending, particularly on Medicaid. Unlike the federal government, almost all states are required to balance their budgets each year.

The increased Medicaid spending has been predominantly attributed to the growth in enrollments that occurred over the first few years of the decade, which was to be expected given the slow job-growth recovery in 2002-03. Less attention has been given to the increased spending associated with the growth of the aged and disabled

population, particularly where such growth is not obviously related to economic conditions.

Over the past 15 years, states have experimented with ways to slow spending for acute care services. Hopefully, some of the flexibility that the Bush administration is proposing and that the states are requesting for long-term care services for the elderly and disabled will help spur state creativity in these areas as well.

On a broader level, the time is long overdue for the nation to rethink the type of program for low-income populations that makes sense for the 21st century. The current Medicaid program misses many low-income individuals. In most years, about one third of the nation's uninsured are individuals below the poverty line who do not qualify for Medicaid for various reasons, including the very low income limitations in some of the state programs. At the same time, the current program covers some who are substantially above poverty. Medicaid has also provided little in the way of coordinated care to the so-called "dual-eligibles," individuals on Medicare and Medicaid, who are among the most expensive populations treated by either program. Finally, for all the money that has been spent on Medicaid, little is known about Medicaid's actual impact on the health status of the low-income population it serves.

Although I am normally reluctant to recommend a new commission to look into transformations of major social programs, Medicaid is an instance where this approach may make sense. Individuals chosen to represent Congress, the administration, and the governors may be able to come to some agreement about what a low-income support program should look like for the 21st century, including that most vexing area of who should be covered under such a program for long-term care and how it should be provided and financed. ●

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**"Spending wisely means reducing wasteful spending that can threaten the viability of essential programs like Medicaid. We must end overpayment for prescription drugs by states and the federal government. We will work with states to ensure that federal Medicaid dollars are spent properly and go to help those in need. And we must close loopholes that allow people who can afford to pay for their health care to shift the costs to Medicaid, and drain resources needed to provide health care for the poorest Americans."**

— President Bush, commenting on Medicaid during his April 23 radio address.