

Block Grants Are the Wrong Prescription for Medicaid

John Holahan and Alan Weil¹

The Bush administration has proposed major modifications to the Medicaid program.² Under its proposal, each state would have the option to obtain more flexibility in program design if it accepts a predetermined allotment of funds in lieu of the open-ended matching funds of the current program. Medicaid, which covered 47 million people at some point during FY 2002 at a total (state and federal) cost of \$256 billion, is now as large as Medicare. Payments for Medicaid account for 43 percent of all grant funds transferred from the federal government to the states. Changes to this program have major implications for the health care system, the people covered, and the relationship between the states and the federal government.

“Converting Medicaid into a block grant moves health policy in the wrong direction.”

Transforming a program that has operated as an individual entitlement with an open-ended funding commitment from the federal government into a block grant has substantial and complex implications that represent fundamental ideological choices.³ While accepting the offer of a block grant is up to each state, having this option available is likely to change the federal government’s approach to administering Medicaid. States that opt for the block grant will presumably be barred from returning to the traditional Medicaid design in order to prevent gaming, thereby constraining the options available to future state lawmakers. All told, converting Medicaid into a block grant changes the states’ and the federal government’s incentives and options, which will yield changes in the program, some predictable and some unknown. This paper examines these changes and discusses their consequences.⁴

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² Information on the administration’s Medicaid plan can be found at “HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan” (http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=766), January 31, 2003, and U.S. Department of Health and Human Services, “FY2004 Budget in Brief,” February 2003.

³ The Bush administration does not refer to its proposal as a block grant. The administration’s budget proposes to give states “significant flexibility” to spend what it calls “lump-sum allotments,” which are determined in advance by formula.

⁴ Other reviews of the implications of a Medicaid block grant can be include Cindy Mann, “The Bush Administration’s Medicaid and State Children’s Health Insurance Program Proposal,” (Washington, D.C.: Georgetown University Institute for Health Care Research and Policy, February 10, 2003); Cindy Mann, Melanie Nathanson, and Edwin Park, “Administration’s Medicaid Proposal Would Shift Fiscal Risks to States” (Washington, D.C.: Center on Budget and Policy Priorities, April 1, 2003); and J. Guyer, “Bush

The Bush Administration Proposal

The administration's proposal—details of which are not yet available—would be voluntary for states, unlike the Medigiant proposal passed by Congress but vetoed by President Clinton in 1995. States choosing the block grant approach would get two allotments—one for acute and one for long-term care. States choosing to take the fixed allotments would be required to continue providing basic services to a core population, presumably the benefits and eligibility groups states are currently required to cover. Mandatory benefits include hospital, physician, laboratory, x-ray, and nursing home services. Mandatory eligibility groups include poor children, children under age 6 and pregnant women with incomes below 133 percent of the federal poverty level, adults who would have met 1996 eligibility standards for welfare, and SSI recipients.

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Payments to states: States choosing the block grant would receive allotments that grow by about 8.5 percent per year, the same rate the Congressional Budget Office (CBO) estimates for program growth under current law.⁵ The growth rate is a major difference between this block grant proposal and the earlier one, which had lower rates of growth and raised immediate concerns about states' ability to continue to fund services for their populations. States choosing the block grant would also be given extra money—about 2 percent more in 2004 and 1 percent more between 2004 and 2010—but all extra payments are taken back after 2010, making the proposal budget-neutral to the federal government over a ten-year period.

MOE requirement: States would have a maintenance of effort (MOE) requirement but this would be less than they are now projected to spend. The MOE would be set at the 2002 base level spending and increase at the rate of the medical care consumer price index. This would allow states to spend less than they are projected to do under current law and still receive the full federal allotment. It is not yet clear how MOE requirements would be defined or enforced, but experience suggests they will be controversial and subject to some manipulation by states.

Objectives of the Proposal

Why has the Bush administration made this proposal?

Achieve fiscal savings: The first reason seems to be fiscal. Medicaid expenditures are projected to grow at 8.5 percent per year for the next decade. Since the proposal retains this growth rate, at first glance it does not appear that saving money in the federal budget is a motivation. But the 8.5 percent figure under current law is just an estimate

Administration Medicaid/SCHIP Proposal” (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 12, 2003).

⁵ Details on methods for determining the growth factor have not been made public, but setting the trend factor at a rate equal to current program growth has been mentioned in public presentations and in the budget.

and the administration may prefer the certainty of a fixed amount, or perhaps it is assuming it could ratchet down the growth rate in the future if federal budgetary pressures make that necessary.

Reduce Medicaid maximization: Second, there is considerable frustration with the variety of Medicaid maximization schemes—disproportionate share hospital (DSH) payments and upper payment limit (UPL) arrangements—states have developed. These arrangements can be structured in many different ways and are estimated to have resulted in \$16 to \$18 billion in federal expenditures with little or no state matching funds. Recent federal changes in 2001 and 2002 have curtailed these efforts to some degree, but federal officials remain nervous that states’ creativity could yield new approaches that will result in another spike in Medicaid spending, as occurred in the early 1990s. Current dire state fiscal conditions give states particularly strong incentives to rely upon accounting tricks to generate federal matching funds. With fixed allotments, the federal budget would no longer be subject to state manipulation.

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Encourage efficiency: Third, the administration hopes to unleash a great deal of creativity at the state level to make Medicaid more efficient. Critics point to Medicaid’s complex eligibility rules, the failure of many eligible people to enroll, the rich benefit package, and the cumbersome waiver process as sources of inefficiency that could be eliminated if states were free to modify the program.

Shift policymaking to the states: Finally, the argument for block grants rests on the view that health policy should be made at the state level. Without federal restrictions states could do a better job reflecting the needs and priorities of their own citizens.

Can Efficiency Reduce Program Costs?

The ideal outcome from converting Medicaid into a block grant would be the generation of programmatic efficiencies that come at no cost to the program’s beneficiaries. Ideally, states freed from federal rules and at greater risk for program costs would have the appropriate motivation and tools to redesign the program. Projected annual growth rates averaging 8.5 percent seem high, and suggest that efficiency savings might be attainable.

Reasons for high-cost growth: Recent cost increases and those projected for the near future are high for several reasons. The first is enrollment. Declining employer coverage for low-income populations, outreach designed to attract enrollment in the SCHIP program, and demographic and medical trends yielding larger numbers of people with disabilities all factor into Medicaid’s enrollment growth. The second is health care inflation. Along with private payers, Medicaid has been hard hit by the growing cost of prescription drugs, recent increases in hospital prices, and the consolidation of providers to counter the negotiating power of managed care plans. The new flexibility provided by this proposal does nothing to address these factors.

While growth in the Medicaid budget is significant, and costs are high per enrollee, Medicaid is not expensive on a risk-adjusted basis.⁶ When one adjusts for the relatively poor health status and high prevalence of disabilities, expenditures on Medicaid beneficiaries are lower than for those with private insurance coverage. These lower costs are due primarily to low provider payment rates, which can impede patient access to services. Obtaining the same services for the same populations at a lower cost is likely to prove quite difficult.

The most likely prospect for efficiencies in Medicaid will come from more substantial reorganization of the health care delivery system. Efforts to reduce medical errors, increase coordination of service providers, and assure appropriate care for those enrolled in the program may yield cost savings, particularly in the longer term. However, there is little indication that these efforts are impeded by the current Medicaid structure and little reason to believe their adoption would be accelerated by converting the program into a block grant.

Can Restructuring Medicaid Coverage Significantly Reduce Program Costs?

If substantial savings from increased efficiency are unlikely, will restructuring benefits and eligibility save states money?

Richness of benefit package: Many policymakers believe that the Medicaid benefit package is too rich, particularly as states have expanded Medicaid eligibility to people with incomes above the poverty level. This sense of richness comes from three aspects: the benefit package covers some services, such as dental and vision care, not included in all commercial insurance; copayments are generally quite low, and may not be imposed on children, pregnant women, and people living in institutions; and states cannot charge premiums to enroll in the program.

“... about two-thirds of Medicaid expenditures are for optional populations and services.”

States currently determine eligibility and benefits within federal guidelines. About one-third of the Medicaid population and about two-thirds of expenditures are for optional populations and services.⁷ States do not have to cover children above the poverty level, adults above 1996 welfare standards, the disabled above SSI levels, or most of the elderly in nursing homes. They do not have to cover drugs, mental hospitals, homes for the mentally retarded, or most community-based long term care services.

If states feel that Medicaid imposes too large a fiscal burden, why don't they cut these optional enrollees and services? The most obvious reason is that citizens value these services. Services for many of the chronically mentally ill, developmentally disabled, and frail elderly are optional in Medicaid lingo, but states feel they have no

⁶ Jack Hadley and John Holahan, “Is Health Care Spending Higher Under Medicaid or Private Insurance?” Report prepared for Kaiser Commission on Medicaid and the Uninsured, forthcoming.

⁷ Kaiser Commission on Medicaid and the Uninsured “Medicaid ‘Mandatory’ and ‘Optional’ Eligibility and Benefits,” July 2001.

choice but to provide them—indeed many of these services were paid for with state funds before Medicaid existed. Once the state chooses to provide these services, including them in the Medicaid program often provides savings to the state, since the burden is shared with the federal government.

Certain optional benefits substitute for more expensive hospital, nursing home, or physician services that are mandatory or reduce demand for social services that states pay for outside of the Medicaid program. The primary example is prescription drugs, but the same can be said for dental care, vision care, prosthetic devices, personal care, case management, physical therapy, and other optional services.

Finally, the strength of provider groups and the economic benefits associated with pulling federal dollars into the state encourage inclusion of optional services and beneficiaries in the Medicaid program.

The new flexibility offered by the proposal: States have at their disposal many mechanisms to cut Medicaid costs. A block grant would provide three new kinds of flexibility: tailoring benefit packages to different groups, expanding the use of cost sharing, and imposing enrollment caps. What would these changes achieve?

Reducing Benefits

One type of flexibility states would obtain under the administration's block grant proposal is to cover different sets of optional benefits for different populations. Under current law, an optional benefit provided to one categorically eligible group of Medicaid enrollees must be provided to all.⁸ The proposal would allow, for example, a state to cover eyeglasses and dental services for children age 6 through 18 in families with income below the poverty level, but not for children in families with income above the poverty level (the latter being an optional eligibility group that the state could choose to not cover at all).

"States have at their disposal many mechanisms to cut Medicaid costs."

In the abstract, with more than 40 million Americans lacking health insurance, the option of reducing benefits to cover more people is appealing. However, the potential benefits associated with this choice are likely to prove quite limited because the new flexibility will add little to the policy options already available and thus provide little additional saving.

An examination of optional benefits under Medicaid reveals relatively few realistic opportunities for saving money. Prescription drugs are optional, and account for about 9 percent of Medicaid spending,⁹ but it is unlikely that reducing this benefit in ways that are not already allowed under current law would yield any savings—in fact it

⁸ Medically needy eligible populations may be offered different benefits. The distinction between categorical needy and medically needy is technical and is not explored here. It is important to note that this distinction is not the same as the distinction between optional and mandatory populations.

⁹ Authors' calculations from CMS Form 64 for 2002.

might increase spending as sick patients turn to more expensive services. About 40 percent of Medicaid spending is on long-term care services for optional populations, such as the elderly and disabled with incomes too high to qualify for SSI. Despite needing nursing home-level care, these people cannot afford it on their own, and it is difficult to imagine eliminating these benefits.

Ultimately, the likely major target for reductions in optional services are acute care services such as prosthetic devices, vision, hearing and dental services, chiropractors and podiatrist services, and medical equipment. Spending on these services for all groups amounted to \$14.1 billion in 1998 or about 7.0 percent of Medicaid spending. But states could eliminate these services for all groups (except children) now and choose not to. No doubt it is politically difficult to cut these services for the disabled and elderly. In the end the ultimate target is likely to be spending on these services by non-disabled adults; this amounted to about \$2.3 billion in 1998 or about 1.5 percent of Medicaid spending on medical services.¹⁰ This is a substantial amount of money, but not enough to help much with state fiscal problems or to allow states to go very far in expanding insurance coverage to new populations.

Increasing Cost Sharing

A second possible source of savings for states operating under a block grant is to make greater use of beneficiary cost sharing. Cost sharing is quite limited in the existing Medicaid program. Premiums may not be charged, deductibles may not be imposed, and copayments may be no more than nominal, and may not be charged to certain eligible groups, including children, pregnant women, and people in institutions. Through waivers some states have begun charging premiums to some enrollees with incomes above the mandatory eligibility levels, but cost-sharing rules cannot be waived.

“Under a block grant, states may cap enrollment to limit their costs.”

Cost sharing for higher income beneficiaries might bring Medicaid in line with the insurance policies Americans obtain through their jobs. But it is not without its problems as a policy tool. Medicaid beneficiaries have quite low incomes (median annual family income for enrolled children was \$16,980 and for nonelderly adults was \$15,363 in 2001).¹¹ Cost sharing can deter use of unnecessary services but can also deter necessary care, defeating the purpose of coverage. Copayments, a common feature of private insurance, impose a very different burden on the typical family with, say, five office visits and three prescriptions filled each year than on a person with a chronic illness requiring regular care. Finally, many providers object to the hassle of collecting small copayments from poor families and view them as equivalent to reimbursement rate cuts, which states can make under current law.

¹⁰ Kaiser Commission on Medicaid and the Uninsured, “Medicaid ‘Mandatory’ and ‘Optional’ Eligibility and Benefits,” July 2001.

¹¹ Authors’ calculations from the March 2002 Current Population Survey.

Capping Enrollment

Under a block grant, states may cap enrollment to limit their costs. This stands in contrast to the current Medicaid program in which all who are eligible must be permitted to enroll. Enrollment caps are employed in other programs, such as Section 8 housing assistance and many states' childcare subsidy systems.

Caps are arbitrary and affect potential beneficiaries regardless of income or health status. They tend to benefit long-term recipients, such as the elderly and disabled, over people whose health status or income fluctuates, which can terminate eligibility and force a person to start again at the end of a waiting list. Enrollment caps for health insurance can create unpredictable inequities. For example, a person who suffers an acute illness may be denied enrollment while a healthy individual with identical income who happened to enroll first retains coverage. Waiting lists do not add much to states' toolkits for cost savings, since under current law states can reduce eligibility, and have shown a willingness to do so during their recent fiscal difficulties.

Shifting Financial Risk to the States

A block grant shifts financial risk from the federal government to the states. This shift makes sense if it will improve efficiency but such a shift is likely to present states with difficult problems. In the current Medicaid program, if costs rise for any reason—including increased enrollment, medical inflation, or new medical technologies—these costs are shared between the states and the federal government. Under a fixed grant program, higher costs are borne entirely by the states, while lower costs create a windfall that states keep in its entirety.

“Shifting risk to states is placing the risk at the level of government less able to absorb it.”

If the next ten years of Medicaid precisely match budget projections, the shift in financial risk would be unimportant. However, history shows that Medicaid spending is quite volatile, just as private sector health insurance premiums are. Annual Medicaid cost growth for health services has ranged from 2.3 to 20.7 percent since 1990. Thus, the shift in risk is likely to be meaningful.

There are two reasons to be concerned about shifting financial risk to states. First, Medicaid enrollment grows during periods of economic weakness, when state revenue collections also are low. Given their balanced budget requirements, states are in a weaker position than the federal government to meet the increased needs of Medicaid at these times. In fact, the current fiscal structure makes Medicaid a countercyclical program, with the federal government spending more when the economy is weak. This structure increases the flow of federal funds to states during downturns, helping both beneficiaries and state economies. A block grant design would likely shift the program to being somewhat procyclical. When the economy weakens federal funds will not increase and states, facing fiscal pressures, are likely to cut spending. (State actions will depend in part on whether they are spending at or above their MOE—see below.) Second, states, with their narrower tax bases and less heterogeneous economies, are subject to greater volatility in revenue collections. Shifting risk to states is placing the risk at the level of government less able to absorb it.

Implications of Changing State Incentives

The move to a block grant changes the incentives states face when considering policies in the Medicaid program. Under a block grant, the marginal benefit to a state from reducing coverage or spending (down to the floor imposed by the MOE) would increase dramatically—from between 23 and 50 cents on the dollar (depending upon the state) to a full dollar-for-dollar; the marginal cost to a state for expanding coverage would increase similarly. In other words, states would get to keep all the savings associated with reducing program coverage or benefits and need not share them with the federal government, but they bear the full cost of eligibility expansions. Recent evidence shows that states are reluctant to cut Medicaid, even though state budgets are very tight. Some of this reluctance would disappear if states saved a full dollar for every dollar they cut. Similarly, when states bear the full cost of expansions they are less likely to make them. In general, a matching formula program encourages expansion—an appropriate policy when more than 40 million Americans are without health insurance. A block grant will likely discourage expansions except in exceptionally good economic times.

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Block Grants and Equity

A block grant would lock in current differences in federal payments across states. In the current Medicaid program, the amount of federal dollars that states receive depends on how they structure their programs, i.e., their policy choices regarding coverage, benefits, and provider payments. The more expansive their programs, the more federal dollars. Federal payments also depend on the federal matching formula, which varies inversely with state per capita incomes. In general, the first factor has a greater effect than the second. Although there are several exceptions, high-income states tend to get more federal dollars per low-income person than low-income states.

The block grant proposal would use FY 2002 federal spending levels in each state and apply a growth factor to determine each state’s yearly allocation. To look at how federal allocations for acute and long-term care would vary across states, we began with 2002 expenditures for acute and long-term care services for each state. We applied the current federal matching rate and divided by the number of people below 200 percent of poverty.¹² Table 1 shows considerable variation in federal payments per low-income person across states.

¹² Acute and long-term care spending is from fiscal year 2002 (CMS Form 64). Population counts are from the March Current Population Surveys for 2001 and 2002. Other population-based denominators may be appropriate. When we used the population below 100 percent of the FPL, there was little change in the results.

**Table 1:
Federal Medicaid Acute and Long Term Care Expenditures Per Low Income Person, FFY 2002**

Acute Care		Long Term Care	
District of Columbia	2,849	New York	1,354
Alaska	1,872	Connecticut	1,299
New York	1,818	Iowa	1,299
Rhode Island	1,811	Minnesota	1,257
Vermont	1,627	District of Columbia	1,125
Maine	1,563	Wisconsin	1,121
Massachusetts	1,537	North Dakota	1,022
Missouri	1,477	Pennsylvania	1,004
Kentucky	1,452	Rhode Island	983
Tennessee	1,388	New Hampshire	969
Mississippi	1,385	Maine	948
South Carolina	1,378	New Jersey	921
New Mexico	1,250	Nebraska	915
Louisiana	1,201	Ohio	909
Delaware	1,188	Missouri	888
Michigan	1,146	Massachusetts	886
New Hampshire	1,142	Vermont	843
Connecticut	1,129	South Dakota	821
Georgia	1,127	Alaska	820
Maryland	1,119	Kansas	805
Minnesota	1,119	Louisiana	741
North Carolina	1,116	Delaware	677
Pennsylvania	1,115	West Virginia	672
New Jersey	1,096	Indiana	650
West Virginia	1,069	Maryland	619
Ohio	1,044	Wyoming	584
Indiana	1,033	Virginia	581
Washington	1,008	Kentucky	577
Oregon	970	Montana	576
Arkansas	963	South Carolina	564
Nebraska	962	North Carolina	558
Illinois	944	Michigan	551
Wisconsin	937	Oklahoma	549
Arizona*	935	Arkansas	549
Alabama	924	Washington	541
Iowa	917	Oregon	524
South Dakota	910	Tennessee	522
Hawaii	881	Mississippi	520
California	876	Idaho	502
Utah	805	New Mexico	501
Idaho	801	Alabama	489
Oklahoma	787	Illinois	442
Texas	732	Hawaii	431
Florida	730	Colorado	395
Montana	728	California	362

Kansas	715	Arizona*	354
Colorado	664	Georgia	345
Virginia	632	Texas	344
North Dakota	618	Florida	337
Wyoming	594	Utah	331
Nevada	511	Nevada	189

Sources: Urban Institute estimates based on data from CMS (Form 64). Population counts from the March Current Population Surveys, 2001, 2002.

Notes: Includes total civilian population. Low-income is defined as having family income below 200% FPL. Does not include administrative costs, accounting adjustments, or the U.S. Territories. Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), disproportionate share payments and payments to Medicare. Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services.

* Of the \$2.9 billion in prepaid/managed care expenditures reported by Arizona, 68% was assumed to pay for acute care and 32% was assumed to pay for long-term care. These proportions are based on data included in the "2002 AHCCCS Overview" report produced by the state.

New York and California, who are often compared with each other, would fare quite differently. In the acute care allocation New York would receive \$1,818 per low-income person while California would receive \$876; the long-term care allocation would be \$1,354 in New York and \$362 in California. In general high-income states such as New York, Vermont, Rhode Island, and Massachusetts would receive the highest allocations. There are exceptions; such low-income states as Tennessee and Mississippi would get relatively high allocations as well.

"A block grant would lock in current differences in federal payments across states."

But more typically, lower-income states such as Florida and Texas would receive considerably less. If low-spending states wanted to expand coverage to levels similar to those of higher-income states they would not receive any federal help. The scale of today's interstate federal Medicaid spending differences is difficult to defend; locking them in is even less so.

Allotments that grow at equal rates among all states also are potentially inequitable. The composition of enrollees and benefits varies among states, as do labor markets, which affect provider costs. State populations also grow at different rates. All have implications for expenditure growth.

How Would States Respond to a Block Grant Program?

One goal of the administration's proposal is to encourage state innovation. While a few states might take bold approaches under a Medicaid block grant—just as a few states have applied for and received Section 1115 waivers to fundamentally transform the program—we anticipate that states innovations will by and large be quite modest. In our assessment, block grants will most likely have the ironic effect of *reducing* innovation for two reasons.

First, block grants lock states in to where they are at the outset and take away the primary tool they need to make changes: money. States are constantly recalibrating their programs, changing payment rates for providers, and considering coverage for new medical technologies, and they periodically add new eligibility groups. Without federal matching funds to cover a portion of the cost, many of these changes will come to a halt.

Second, as described above, block grants shift a large financial risk to states. The natural response to this shift is to seek to reduce other sources of risk. Major policy changes are precisely the sort of risk states are likely to avoid to provide themselves with some stability in an increasingly uncertain fiscal position.

Ultimately, how states respond to block grants will depend primarily upon whether the underlying costs of the program increase at a rate faster or slower than the statutory 8.5 percent, or whatever growth rate is ultimately agreed upon.

The best-case scenario is that block grants are enacted and medical inflation is low, the economy is strong, and no major health care system shocks occur for a sustained period. Experience tells us that in this scenario, the existing Medicaid program might have grown at a rate of 4 or 5 percent. States would receive a federal grant that grows at a much higher rate, and with the maintenance of effort requirement, actually must spend more on health care than they need to cover the “old” program’s cost. These extra dollars create room to fund other priorities: expansions of benefits, coverage for new populations, and greater investment in community-based services.

“Block grants will most likely have the ironic effect of *reducing* innovation.”

A more pessimistic scenario is that block grants are enacted and followed by a period of high medical inflation, a weak economy, and one or more shocks to the health care system. The combination of the federal block grant and the state’s maintenance of effort is insufficient to cover the costs of the eligible population. Some states would dig deeper into their own pockets to cover the costs, while others would cut provider payment rates, optional benefits, and optional eligibility groups.

Over time, states will have good and bad years, with results that depend upon whether the state is spending more than is required for maintenance of effort. In good economic times, states with more limited programs may find that maintenance of effort requirements and growing federal block grant funds will force them to expand coverage more than they otherwise would just to spend the required funds. In bad times, those states will scale back coverage to keep their spending close to the required minimum. For states that are willing to spend more than the minimum required, in good economic times they will expand their programs because they have the resources, but expansions will be less ambitious than they are today because the state will bear the full cost. In bad times these states will cut back more quickly than they do now because they will keep all the savings—no longer sharing them with the federal government.

The net result is that for states with more limited programs the block grant design is more stable from a budget perspective—with fairly predictable and controllable rates

of growth each year as the federal grant and the state effort both rise by formula. In order to achieve this stability, states will need to (and will have more tools that enable them to) adjust eligibility, benefits, and payment rates, and perhaps establish waiting lists, each year. For states that want to go beyond the minimum the incentives in the block grant design are likely to reduce the pace of expansion and accelerate the pace of contraction. This increase in budget stability will come at the expense of lower overall rates of insurance coverage.

The Bottom Line

Ultimately, the problem with the block grant approach is that it is not real Medicaid reform. The new flexibility states would gain—tailoring benefits, altering eligibility criteria, imposing more extensive cost sharing, establishing waiting lists—add only modestly to the tools states have. The basic dynamics of the Medicaid program would remain unchanged: When health care costs are under control the program will expand to meet new needs, and when costs spiral higher the program will be cut. Block grants mean the details of the expansions and cuts will be different, but the cycles remain.

“Ultimately, the problem with the block grant approach is that it is not real Medicaid reform.”

Real Medicaid reform must confront two problems facing the Medicaid program. First, the cost of meeting the acute and long-term care needs of the poor, elderly, and disabled is growing faster than current state tax revenues. This problem will remain even after economic growth resumes. Second, variation across states in how well Medicaid meets the needs of the low-income population and how many financial games have been played makes the federal government reluctant to build upon Medicaid’s strengths. Real reforms would promote a more cost-effective health care delivery system and a more rational allocation of financial and programmatic responsibility among employers, families, states, localities, and the federal government.

States are less able than the federal government to bear financial risk and engage in policies that redistribute income. When faced with the full cost of any policy changes, rather than the sharing arrangement in the current Medicaid program, states are less likely to expand coverage and more likely to make large cuts in difficult times. Predetermined budget allocations lock states in to the policies and priorities chosen in the past. If meeting the health care needs of the poor and the sick is a national priority, the federal government’s role must remain larger than writing checks to states. Converting Medicaid into a block grant moves health policy in the wrong direction.

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