



The National Governors' Association Medicaid Proposal:

Overview and California Implications¹

INTRODUCTION

During their recent winter meeting, the National Governors' Association unanimously adopted a proposal to reform the nation's Medicaid program. In response to the bipartisan plan, House and the Senate Committees are conducting a series of hearings to examine the Governors' recommendations. Given the role the Governors' plan could play in resolving the Medicaid reform stalemate and California's status as the second largest Medicaid recipient state, it is important to closely consider the plan's state-specific implications. This paper outlines the major provisions of the Governors' proposal and examines their potential impacts on California.

THE PROPOSAL²

Eligibility. Under the National Governors' Association proposal, eligibility remains guaranteed for the following populations: pregnant women to 133 percent of poverty, children to age 6 to 133% of poverty, children age 6 to 12 to 100% of poverty, the elderly who meet SSI income and resource standards, persons with disabilities as defined by the state in their state plans and either (1) individuals or families who meet current AFDC income and resource standards or (2) states can run a single

¹ Prepared by Darby Morrisroe, Research Fellow, California Institute for Federal Policy Research, February 28, 1996. For further information on block grant funding of Medicaid, see "The Distribution of Federal Medicaid Dollars: California Fiscal Implications of Block Granting and Other Approaches".

² National Governors' Association, "Medicaid Reform", as adopted February 6, 1996, Washington D.C.

eligibility system for individuals who are eligible for a new welfare program as defined by the state. Coverage would remain optional for all other optional groups in the current Medicaid program and for other individuals or families as defined by the state but below 275% of poverty.

Benefits. Consistent with the statute, adequacy of the state plan would be determined by the Secretary of HHS. The following benefits would remain guaranteed for the guaranteed populations only: inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. States would have complete flexibility in defining amount, duration and scope of services.

Financing. Each state would have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation would be available to states which provide a matching percentage (methodology to be defined). The allocation is the sum of four factors: base allocation, growth, special grants and an insurance umbrella.

Base Allocation. A state may choose a base allocation from their FY93, FY94 or FY95 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.

Growth. This is a formula that would account for estimated changes in state's caseloads (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the available data.

Special Grants. Special grant funds (no matching requirement) will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans.

Insurance Umbrella. The umbrella is designed to insure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for all guaranteed populations and the optional portion of the disabled and the elderly. These funds are an entitlement to states and are not subject to annual appropriation.

Matching Percentage. A state's matching contribution in the program will not exceed 40%. (The current floor is 50% and the ceiling is 83%; California is presently at the 50% level.)

Provider Standards and Reimbursement. States would have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan. The Boren Amendment and other Boren-like statutory provisions, which require states to pay "reasonable and adequate" provider rates, would be repealed.

CALIFORNIA IMPLICATIONS

Base Year Allocation -- Of primary concern to California and most other states, will be the grant level. The Governors' proposal, like most other Medicaid reform plans now being discussed,

incorporates a base year expenditure level in determining future year allocations. This approach would place California at a disadvantage relative to other states. Due to aggressive cost control efforts, California has a relatively low per-patient Medicaid spending. California and other low-expenditure states could be penalized for having already squeezed out excess spending, while New York and other high-expenditure states could be rewarded for having not yet done so. The Urban Institute found that basing block grants on current expenditures would freeze federal Medicaid payments per poor person (below 150% of poverty) at more than \$2,000 for New York, Rhode Island, Massachusetts and Connecticut, compared to roughly \$800 for California. (The U.S. average was found to be about \$1,000 per poor person.) On the other hand, the study suggested that "a more equitable allocation formula" such as basing grants on the number of poor persons in a state would yield vastly different results, and these results would be much better for California. California's federal allocation under such an alternative scheme would increase 22%, from \$6.8 billion currently to \$8.2 billion, whereas New York's allocation would decrease 53%, from \$9.8 billion to \$4.6 billion. In general, the South, West, Midwest and Mountain states would gain under such a scheme, while states in the Northeast would lose.³ In sum, allocating Medicaid according to the number of persons in poverty would be vastly more equitable, and better for California.

Growth Factor -- In addition to a base allocation, the Governors' proposal would allow for a growth factor to be included in the financing formula. While accommodating Medicaid growth is desirable in any formula, the specific details of the growth factor are important when determining its potential impact on California. An important question would be whether the growth factor is determined by projected growth in each state's Medicaid population or on total U.S. Medicaid figures, with the former being a better approach for growing states. It appears that the Governors would use state-by-state growth rates. Although the details of the insurance umbrella are not well defined, it could be helpful in compensating for unanticipated caseload growth in the state.

Although the Governors' current proposal accounts for caseload growth rather than expenditure growth, the usage of a base year allocation will have the effect of imposing a per capita expenditure cap. Care should be taken to ensure that California is not penalized for having kept spending low. If the Governors' scheme is adopted, states such as New York with more Medicaid "fat" to cut will have an easier time keeping to a per capita expenditure cap than states which already run lean operations. The Urban Institute study of state Medicaid spending variations concludes that block grants and per capita expenditure caps would favor high income states. California, however, is an exception to that general rule. Despite California's relatively high income (ranking 12th of the 50 states), a block grant based on a FY95 level or a growth cap at a certain percentage would work against California's interests.⁴

Reduction of the FMAP Floor -- Under the current Medicaid formula, no state may have a matching percentage (FMAP) below 50%. If a state's FMAP would otherwise be below 50%, the formula raises it to 50%. The Governors' proposal would *raise* the FMAP floor to 60%, which would reduce the share that the California would have to pay to 40% thus easing strain on the state budget. On the other hand, *lowering* the floor would reduce further the percentage reimbursement to states which theoretically are better able to pay for services themselves. While California is now at the 50% mark because its per capita income is relatively high, reduction of the 50% floor would not affect California because our state is very near that 50% threshold. In fact, California would be above that threshold if the most current income data used were used; the 50% mark is retained for California only because the formula is based on a 3-year backward-looking per capita income average. Several

³ Policy Brief, The Kaiser Commission on the Future of Medicaid, March 1995 (Prepared by the Urban Institute)

⁴ Urban Institute, Ibid

higher-income states (Connecticut, New Jersey, New York, Massachusetts, etc.) would be impacted significantly by a reduction in the 50% floor because their floor-less FMAP would be considerably lower. (Connecticut's would be the lowest at 17%.)

Treatment of Illegal Immigrants -- The Immigration and Naturalization Service estimates that 43% of the nation's undocumented immigrants reside in California, though precise figures are difficult to pinpoint. Governor Wilson's office estimates that in 1995-96, more than 300,000 illegal immigrants will be provided emergency- and pregnancy-related health care services in the state, at a cost of \$395 million. The NGA proposal would make funds available to states to cover the costs of providing Medicaid services to illegal immigrants. The plan does not specify whether these funds would be an entitlement to states or subject to an annual appropriation. While California would benefit from any funds reimbursing states for costs associated with serving illegal aliens, the direct impact on the state will be determined by the amount of special grant funds available and their method of distribution among the states.