

Fiscal Facts

Federal Reserve Bank of Boston

States May Face Higher Spending in Give-and-Take of Medicare/Medicaid Changes

by E. Matthew Quigley

Thursday, July 1, 2004, brought the beginning of fiscal year 2005 and, after several gloomy days, a markedly improved outlook for state finances. Despite this good news, New England's states still face significant fiscal pressures moving forward into the current and next fiscal years. Prominent among these challenges are two changes to the Medicaid and Medicare programs that could significantly increase state health care costs.

Fiscal Year 2005: Declining Federal Medicaid Assistance

In response to the recent fiscal crisis facing many states, Congress provided \$20 billion in temporary fiscal relief in May 2003. Half of this money came in the form of a temporary increase in the Federal Medical Assistance Percentage (FMAP), the rate at which the federal government reimburses states for Medicaid expenditures. Specifically, the Jobs and Growth Tax Relief Reconciliation Act of 2003 temporarily increased each state's FMAP for the period April 1, 2003, through June 30, 2004. The FMAP of each New England state was increased by 2.95 percentage points.

As of June 30, the FMAP reverted to 50 percent for Connecticut, Massachusetts, and New Hampshire; 56 percent for Rhode Island; 61 percent for Vermont; and 66 percent for Maine. This return to the standard rates represents a significant funding reduction for the states at the start of fiscal year 2005.

Each state's FMAP is determined by the following statutory formula:

$$1 - \left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * 0.45 \right]$$

Under this formula, a state's federal matching rate is based on the ratio of its per capita income, squared, to the average per capita income of all states, squared. States with per capita incomes above the national average receive a lower federal matching percentage; states with per capita incomes below the national aver-



age receive a higher percentage. A state with average per capita income has an FMAP of 55 percent. The effect of the squaring is to increase the range of matching percentages. The operation of the formula is bounded by two statutory limits: a minimum of 50 percent and a maximum of 83 percent.¹

The FMAP produced by this formula applies to a state's spending for almost all covered services on behalf of almost all Medicaid beneficiaries. Higher FMAPs have been established for a few services and populations. For example, in the case of family planning services and supplies, each state's costs are matched at 90 percent, regardless of its normal FMAP, to reflect a national priority on public health. Similarly, when a state buys any covered service — hospital care, physician services, prescription drugs, etc. — on behalf of a Native American or Alaskan Native beneficiary from a facility run by the Indian Health Service (IHS) or a tribal contractor to IHS, the federal matching rate is 100 percent. This ensures that state funds are not used to pay for services at federal facilities. Finally, to encourage states to take up the option of covering uninsured women who need treatment for breast or cervical cancer, the cost of treatment for these women is matched at the same higher FMAP that the state receives under the State Children's Health Insurance Program (SCHIP).

The FMAP formula does not apply to administrative costs. In this case, the matching rates vary by function, not by state. The basic matching rate for Medicaid administrative costs is 50 percent in all states. Higher rates apply to some administrative activities, such as the survey and certification of nursing facilities and fraud investigations and prosecutions.

Twelve states had FMAPs of 53 percent in FY2004 (including the temporary increase of 2.95 percentage points): California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, and Washington. Most of these states would have had FMAPs lower than 53 percent if it were not for the statutory floor constraining the operation of the formula. At the other end of the range, ten states had matching rates of 74 percent or more.²

The expiration of the 2.95-percentage-point increase, though seemingly small, is a major loss of funds to New England and will have a significant impact on budgets. As shown in Table 1, the decrease is nearly 10 percent in the case of Maine and exceeds 6 percent in all New England states. On average, the New England states spend roughly 18 percent of their budgets on Medicaid (Table 2), making Medicaid one of their largest single expenditures and a sizable area to be cut so significantly.

Table 1. Loss in Funds to the New England States Resulting from Decrease in Federal Medical Assistance Percentage, FY 2005

	Millions of Dollars	Percent Change FY 2004-FY2005	Percent of FY 2005 Budgeted Expenditures
Connecticut	165	-6.4	1.18
Maine	49	-9.7	1.62
Massachusetts	190	-6.4	0.83
New Hampshire	33	-6.4	0.74
Rhode Island	49	-7.3	0.83
Vermont	25	-8.7	1.62

Source: Author's calculations based on National Association of State Budget Officers data.

Table 2. Medicaid as a Percent of Total State Expenditures, New England States

	FY2001	FY2002	FY2003
Connecticut	20	21	22
Maine	12	12	14
Massachusetts	25	23	24
New Hampshire	19	19	20
Rhode Island	17	18	17
Vermont	11	12	12

Source: National Association of State Budget Officers, state budget documents.

Fiscal Year 2006: Medicare Part D

During FY2006, which begins on July 1, 2005, a second pending change to the system for financing public health care could also impose significant costs on the New England states. This second change is the voluntary prescription drug benefit — “Part D” of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law on December 8, 2003. This new benefit is the largest expansion of the Medicare program since its inception in 1965.

Under the law’s provisions, the federal government will provide prescription drug coverage to those individuals dually eligible for Medicaid and Medicare, a responsibility currently resting with the states.³ But the federal government is not simply taking over this spending and letting the states off the hook. The legislation contains provisions for a phased-down contribution from the states — popularly referred to as a “clawback” provision — designed to reimburse the federal Treasury for much of the program’s costs.

Beginning on January 1, 2006, each state participating in the Medicaid program will be required to make monthly payments (MSPs — monthly state payments) to the federal government based on the following statutory formula:

$$MSP = \left(\frac{1}{12} \right) * PerCapitaExpenditures * DualEligibles * PhaseDownPercentage$$

“Per Capita Expenditures” (PCE) are a state’s total per capita Medicaid spending on prescription drugs for dual eligibles in calendar year 2003, inflated by the projected percentage rise in total prescription drug spending nationally since 2003. Such spending is currently projected to increase by 13 percent in 2004, 12 percent in 2005, and 12 percent in 2006.⁴ The “Dual Eligibles” variable is defined as the number of full dual eligibles in a given month enrolled in a Part D plan or in a Medicare-approved alternative plan that offers full prescription drug coverage. The “Phase-Down Percentage” (PDP) begins at 90 percent in calendar year (CY) 2006 and drops by 1 and 2/3 percentage points each calendar year through CY2015. For CY2015 and beyond, the PDP will remain constant at 75 percent (Table 3).

Using a hypothetical example to illustrate, if, in January 2006, a state had 100,000 full dual eligibles enrolled in prescription drug plans, and if its per capita Medicaid spending for prescription drugs for these dual eligibles was \$1,000, then the state’s payment amount for the month would be \$7.5 million ($1/12 \times \$1,000 \times 100,000 \times .90$). Placing this example in context, Massachusetts had 193,000 full dual eligibles in 2002, the latest year for which data are available (Table 4). Its per capita spending for prescription drugs for these individuals was \$1,058. If we assume for the sake of example that these 2002 numbers apply to 2006, we can plug these data into the statutory formula and compute that Massachusetts’ monthly payment would be \$15.3 million ($1/12 \times \$1,058 \times 193,000 \times .90$).

Critics see a number of flaws in this formula for determining how much the



Table 3. Phase-Down Percentage

Calendar Year	Percentage
2006	90
2007	88 1/3
2008	86 2/3
2009	85
2010	83 1/3
2011	81 2/3
2012	80
2013	78 1/3
2014	76 2/3
2015	75

Source: Congressional Budget Office.

Table 4. Dual Eligibles and Full Dual Eligibles in New England, 2002

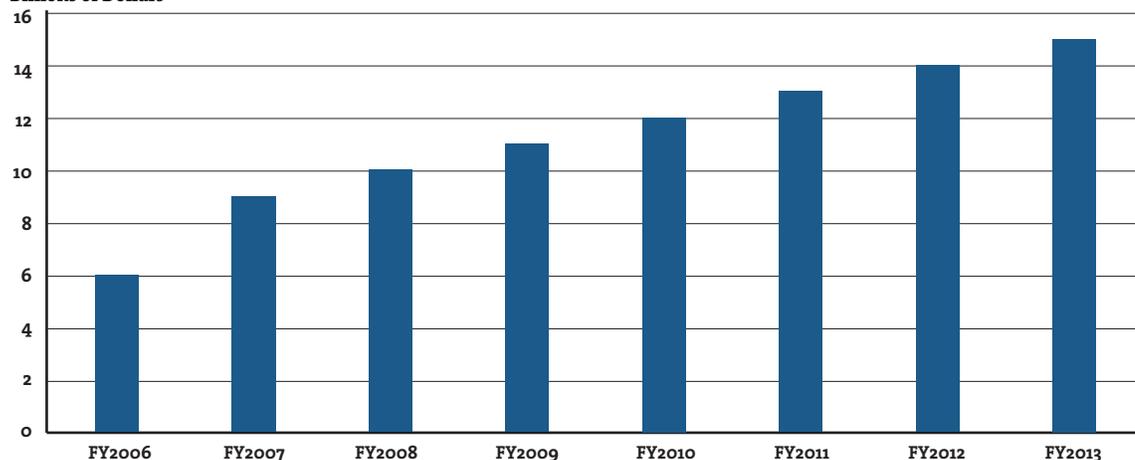
	Dual Eligibles	Duals as a Percent of		Full Dual Eligibles	Full Duals as a Percent of All Dual Eligibles
		All Medicaid Enrollees	Aged and Disabled Enrollees		
Connecticut	83,000	17	71	76,000	92
Maine	49,000	21	64	42,000	85
Massachusetts	216,000	17	61	193,000	89
New Hampshire	20,000	16	72	19,000	93
Rhode Island	33,000	16	59	27,000	82
Vermont	28,000	17	73	22,000	77

Source: Urban Institute estimates based on data from Medicaid Statistical Information System.

Figure 1: Projected Clawback Payments

FY2006-FY2013

Billions of Dollars



states should reimburse the federal government. For example, the PCE measure is not necessarily an accurate proxy for how much a state will save when the federal government takes over responsibility for dual-eligibles prescription drug spending. States that happened to have high per capita prescription drug spending on dual eligibles in 2003 would have their clawback amounts calculated each year on this high spending base, putting them at a perpetual disadvantage. With the application of the trend factor (the national rate of increase in prescription drug spending), this disadvantage would increase relative to states having low 2003 per capita expenditures.

The trend factor itself is another weakness in the formula. If the rate of increase in a given state's prescription drug spending is less than the projected annual rate of increase in prescription drug spending *for all populations nationally*, the clawback formula would produce a required payment that is too high. Eventually, the required payment could exceed the state's actual savings. Under this scenario, states that effectively manage their future drug costs and keep spending growth down could end up paying a penalty for their effective management.

The Congressional Budget Office (CBO) estimates that between FY2006 and FY2013, states will pay in the aggregate approximately \$88.5 billion toward Medicare Part D coverage, constituting the largest-ever single intergovernmental transfer of funds from the states to the federal government. Figure 1 shows the expected size of this transfer. To place this flow of funds in context, the second largest category of payments from the states to the federal government is premium payments for Medicare Part B and Part A.⁵ In 2006, these premium payments are expected to total \$3.5 billion; state clawback payments are expected to total \$6 billion.

The clawback provision carries a multitude of additional implications for the states. Chief among these, as pointed out in a recent publication by the Kaiser Commission on Medicaid and the Uninsured, is that "the clawback links state fiscal liability for Medicare Part D financing directly to federal budget policy."⁶ As of 2006, state clawback payments will be factored into the federal budget. As a result, if Medicare Part D expenditures are higher than projected, Congress may choose to increase state clawback payments as a means of addressing any shortfalls that may arise.

Another important concern is the extent to which the clawback provision limits states' ability to control costs. Under the law, the only meaningful way for states to avoid paying the clawback is to withdraw from the Medicaid program entirely — a highly unlikely scenario. Short of this action, states may take certain steps to reduce the number of dual eligibles covered within a given month, but this would be difficult to do and the impact would be minimal.

On a technical level, a number of logistical issues as yet unresolved remain as points of significant budgetary uncertainty to the states. Implementation of the clawback formula will, for example, require negotiations between state and federal officials over appropriate data sources to use, imputation of data in some instances, and a myriad of other administrative and reporting decisions. These decisions are being made concurrent with planning for the implementation of Part D in 2006. In the end, without a doubt, Part D of the new prescription drug bill offers considerable uncertainty for state budget officials.

¹ Section 1905(b)(1) of the Social Security Act, 42 U.S.C. 1396d(b)(1).

² The program is designed to be a countercyclical program. During an economic downturn, as more people become unemployed and eligible for the program, it expands. The Urban Institute, for example, has estimated that an increase in the unemployment rate from 4.5 percent to 5.5 percent would result in an increase in Medicaid enrollment of 1.6 million people.

³ For a detailed discussion of the prescription drug benefit and its implications for the New England states, see *New England Fiscal Facts*, No. 32.

⁴ Heffler, S. *et al.*, "Health Spending Projections through 2013," *Health Affairs*, Web Exclusive, February 11, 2004, <http://content.healthaffairs.org/cgi/content/full/hlthaff.wf.79v1/DC1>

⁵ Medicare Part B, funded by beneficiary premiums (co-payments by Medicare recipients) and federal general revenues, covers physician and outpatient hospital care as well as other medical screening and prevention services. Medicare Part A covers inpatient hospital care, home health care following a hospital stay, and hospice care. The federal government finances Part A with payroll taxes accumulated in a trust fund.

⁶ Schneider, Andy, "The 'Clawback': State Financing of Medicare Drug Coverage," Kaiser Commission on Medicaid and the Uninsured, June 2004.