



**Testimony before the
House Energy and Commerce Committee**

Subcommittee on Health

**Hearing on
H.R. 5613
Protecting the Medicaid Safety Net Act of 2008**

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Mr. Chairman and members of the Committee, it is a pleasure to appear before you today. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, a Washington-based think tank. I am also part of a bipartisan group of budget experts who believe Congress must address the rapidly growing mismatch between federal spending and revenues that threatens our ability to finance important policy priorities. In a paper released this week, we argue that the first step toward restoring budget responsibility is to reform the budget decision process so that Social Security, Medicare, and Medicaid—the major drivers of escalating deficits—are no longer on auto-pilot.

Medicaid is an important part of our health system, paying for the acute- and long-term care needs of millions of low-income and disabled persons. It is also a source of considerable friction between the federal government and the states. There is ongoing disagreement about what the federal government should pay for in Medicaid and how much it should pay. Today's hearing highlights a concern that the states and some members of Congress have over regulatory actions meant by the U.S. Department of Health and Human Services (HHS) to clarify payment rules and reduce spending that it deems unnecessary.

My testimony will highlight the major reason for such intergovernmental disputes: the use of a matching formula to determine a variable federal subsidy rather than a fixed amount. I will also describe the likely path of Medicaid spending over the long term and the need for Congress to directly consider the impact of policies beyond the budget window for Medicaid and the other major entitlement programs.

A Governance Issue

The ongoing debate over regulatory actions proposed by HHS to alter or clarify some of the details of its Medicaid financing policy stems from an important matter of program governance. How should the Medicaid program be managed to ensure that beneficiaries receive appropriate and effective health care while maintaining fiscal discipline? This question naturally arises because Medicaid is a shared responsibility. The federal government pays a substantial part of the program's cost through open-ended matching grants but the states operate Medicaid on a day-to-day basis.

It is essential that the federal government maintain and strengthen its oversight of this \$350 billion program. Numerous investigations conducted by the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG), as well as decades of experience, demonstrate the financial and policy risks associated with the current matching rate mechanism. However, payment rules are subject to interpretation, and local issues are difficult to resolve from Washington. Consequently, congressional oversight of HHS policies and regulations affecting Medicaid is essential to help ensure that state concerns are fully aired, and that regulations are developed in an orderly process that protects the interests of the taxpayers and Medicaid beneficiaries.

H.R. 5613, Protecting the Medicaid Safety Net Act of 2008, would stop such a process in its tracks by preventing HHS from further developing, refining, and implementing seven proposed or final regulations that have been advanced over the past year. Moreover, the Act does not envision Congressional action on these regulations over the next twelve months. It is difficult to see how any of the objections raised against these regulations can be resolved by prohibiting further work on them. Without some clarification, the states will remain uncertain about the program's rules of the road.

There is a further cost of delaying the regulations that directly affects Congress. If H.R. 5613 is enacted, federal spending would increase by \$1.65 billion over the next two years—not very much money relative to the size of Medicaid. Under the pay-as-you-go rules prudently adopted in this Congress, spending offsets will be needed. To avoid unnecessary controversy, offsets should be identified in an open and bipartisan manner.

Perverse Financial Incentives Breed Conflict

Whether or not Congress stops HHS's work on the seven regulations in question, the tension between the federal government and the states over Medicaid will continue unabated. There will continue to be disputes over the appropriateness of state actions to increase the flow of federal funds. There will continue to be new regulations piled on top of old that attempt to clarify accounting procedures and program rules. Every new regulation will open up yet another avenue of state action and another cause for dispute.

The source of this ongoing problem is not found in a single set of regulations. The problem is the structure of Medicare financing, which splits the costs between the federal government and the states in a way that promotes federal micromanagement.

As an alternative to the current matching formula, federal block grants would resolve many of the disputes between the two levels of government since many of the financial methods now in use would no longer affect the amount of the federal payment. There is already a tradition of negotiating an aggregate target for state drug expenditures in Medicaid. This allows maximum flexibility for each state to manage its program while assuring HHS that expenditures will remain under control. However, states are concerned that a block grant covering the entire program might not fully account for the growth in Medicaid enrollment in an economic downturn or for unexpected increases in the cost of health care.

An alternative proposal would cap the federal Medicaid contribution on a per-beneficiary basis without imposing an overall limit on program spending. Under such "per-capita caps", the federal government and the states would share the risk of higher enrollment rates. States would have a strong incentive to manage their programs in a cost-effective manner since they would be liable for per-capita spending above the capped amount.

Block grants or per-capita caps are not panaceas, but they would raise the federal focus from the details of accounting to the broader concerns of national policy. States would have greater flexibility to innovate, and the federal government would have less reason to dictate to states what they could or could not do.

The Coming Fiscal Crisis

We are about to meet an enormous fiscal challenge head on, and Medicaid is a major part of that challenge. Some 80 million baby boomers are rapidly reaching the age at which they can draw benefits from Social Security and Medicare, and substantial numbers are already enrolled in Medicaid. These three entitlement programs will experience high spending growth over the next few decades, outrunning growth in the overall economy and threatening to crowd out other policy priorities in federal revenue.

By far the fastest spending growth is expected in the health programs. Not only will many more people become eligible for Medicare and Medicaid, but average health spending per enrollee is likely to continue its upward spiral. If present trends continue, Medicare and Medicaid will rise from 4.1 percent of GDP in 2007 to 8.1 percent in 2030, and 12.0 percent by 2050.¹ By that estimate, health programs will consume an ever-increasing share of federal tax revenue, which has averaged 18 percent of GDP over the past 50 years. Moreover, the pressure that Medicaid is already putting on state budgets will increase enormously.

What Should Congress Do?

It is no surprise to policymakers that runaway health spending is contributing to a growing fiscal crisis. The Medicare trustees have been warning about impending imbalances in that program, and the states have made it clear that Medicaid spending is becoming unsustainable for them. As the cost of health care continues to explode, the health programs will absorb a larger share of tax revenues, leaving little room for new policy initiatives.

A significant part of the problem is the automatic nature of spending in Medicare and Medicaid. Except in periods of crisis, entitlement programs are on auto-pilot. As the entitlements grow, there is less money available in the budget for housing, education, energy, transportation, and the other discretionary programs. There is no mechanism in our federal policy process that forces policymakers to look at the broader picture and re-establish some balance across programs competing for scarce resources.

We need to establish the preconditions necessary to encourage elected officials to make the hard choices that will be needed if we hope to regain control of the budget. As a member of a bipartisan group of budget experts who have been working on this issue, I offer the following suggestion for reforming the budget process.²

The budget expert group proposes that the Congress and the president adopt explicit, sustainable long-term budgets for Medicare, Medicaid, and Social Security.

Periodically, perhaps every five years, the CBO would determine whether the programs were remaining on the agreed-upon long-term path of outlays and revenue. If a program was off course fiscally, the Congress and the president would try to come to agreement about an appropriate change in policy. If agreement was not reached, a budget trigger would automatically reduce spending or increase taxes (or some combination) enough to put the program back on course.

This proposal would change the way decisions about long-term spending commitments are made, but they would not automatically solve the fiscal crisis that will soon be precipitated by entitlement programs. That will still require innovative thinking, political risk-taking, and bipartisanship.

A major reform of Medicaid financing should be placed on the agenda for the next administration. That should not absolve HHS and Congress from continuing to be good stewards of taxpayer dollars, and it should not prevent HHS from taking appropriate actions necessary to maintain the fiscal integrity of Medicaid.

¹ Congressional Budget Office, *The Long-Term Budget Outlook*, December 2007. The estimates include only the federal portion of Medicaid spending.

² Joseph Antos et al., *Taking Back Our Fiscal Future*, April 2008, available at http://www.aei.org/publications/filter.all.pubID.27743/pub_detail.asp.