Medicaid and Federal Cost-Shifting: A Zero-Sum Game

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On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (“the 2006 budget”).¹ The 2006 budget reduces Medicaid and SCHIP spending by $4.7 billion over five years and $26.4 billion over 10 years, with nearly all the savings coming out of Medicaid.² The majority of these cuts are anticipated to come from changes in financing prescription drugs, restrictions on asset transfers for individuals seeking Medicaid coverage of long-term care, and the relaxation of prior restrictions on imposing cost-sharing requirements and premiums on certain classes of Medicaid beneficiaries.³ As a result of the 2006 budget, for example, states will now be permitted to impose cost sharing and premiums on most classes of Medicaid beneficiaries, totaling up to 5% of the monthly or quarterly income of beneficiaries earning more than 100% of the federal poverty level.⁴

One provision of the 2006 budget requires Medicaid applicants to provide proof of citizenship when seeking benefits or renewal of benefits.⁵ Presently, most states require no such proof. In a 2005 study by the federal Office of the Inspector General (“OIG”), the Medicaid Directors of nearly all states – 46, and the District of Columbia – reported that Medicaid applicants in their states merely self-declare under oath that they are a U.S. citizen.⁶ Most of these jurisdictions require applicants to provide proof of citizenship only where they believe the applicant’s statement is “questionable.”⁷ And only 20 of the 47 routinely monitor the accuracy of the self-reports by checking the citizenship of at least a sample of their applicants.⁸

When asked what would happen if they were required to make applicants provide proof of citizenship, the Medicaid Directors replied generally that it would result in increased costs.⁹ Many stated they would need to hire more personnel or pay them for extended hours spent collecting and processing the new data.¹⁰ Additionally, applicants would

³ Id. at 35-40.
⁵ Id. at § 6036, 120 Stat. 4, 80 – 81 (2006).
⁷ Id.
⁸ Id. at 11.
⁹ Id.
¹⁰ Id.
incur increased costs through having to obtain the required documents, many of which they may not already have. The Medicaid Directors also believed that it would slow down eligibility determinations. While the OIG did not investigate whether many applicants incorrectly stated their citizenship status on their Medicaid applications, state Medicaid Directors in the OIG study reported that they had not found problems with false declarations through their post-application monitoring.

The new documentation requirement received no attention from the Congressional Budget Office (“CBO”) in the CBO’s 2006 budget cost estimates. Yet the provision is unlikely to be cost-neutral, at least to states. It stands to reason, as many of the Medicaid Directors realized, that requiring documentation of citizenship from all Medicaid applicants may increase both processing costs and time. While it is possible that such costs will ultimately be canceled out through savings on benefits that will no longer be paid to ineligible individuals, such a result cannot be assumed, absent supporting data.

Despite likely increased administrative costs as a result of the new documentation requirement, President Bush now seeks in his 2007 budget proposal to reduce the share of administrative costs that the federal government pays to the 46 states that pool their administrative costs for determining an applicant’s eligibility for Medicaid, Transitional Assistance to Needy Families (“TANF”), and Food Stamps. The President in his 2007 budget proposal states that administrative costs for making eligibility determinations common to Medicaid, TANF and Food Stamps were “generally” included in the

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11 Id. The Center for Budget and Policy Priorities (“CBPP”) estimates that 3.2 to 4.6 million Medicaid beneficiaries who are U.S. citizens do not possess the necessary documents and thus may risk losing their benefits. Leighton Ku et al., Survey Indicates Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens, at 6 (Feb. 17, 2006), available at http://www.cbpp.org/1-26-06health.htm (last visited May 6, 2006).

12 Id.

13 Id. Only one state, Oregon, performed a formal audit regarding the matter. In it, it found that 25 out of 812 applicants made an incorrect declaration. It estimated that incorrect declarations could result in an average of $2 million per year paid from Oregon coffers in Medicaid benefits to ineligible individuals. Id. at 13-14.

14 While I am not aware of any studies that estimate the amount it costs to verify citizenship or appropriate residency for Medicaid in the four states that require documentation, the Kaiser Commission on Medicaid and the Uninsured did a survey in 2001 that looked at the cost savings six states experienced in eliminating their Medicaid asset test. The one state that examined the cost of dropping the test found that verifying applicants’ assets cost the state approximately $3.5 million, and that the state likely would pay $2.5 million in benefits to applicants who would have been eliminated through the asset test. Thus, Oklahoma estimated it would save money through elimination of the test. See Vernon K. Smith et al., Eliminating the Medicaid Asset Test for Families: A Review of State Experiences, at 13 (Apr. 2001), available at http://www.kff.org/medicaid/2239-index.cfm (last visited Feb. 21, 2006).

15 It is possible, as CBPP notes, that savings will not come merely from unpaid benefits to ineligible individuals, but also through excluding eligible individuals who, for one reason or another, cannot or will not obtain the required documentation. See Leighton Ku, supra, note 11.

administrative cost calculations for states’ TANF block grants.\textsuperscript{17} By additionally covering 50\% of states’ costs for Medicaid eligibility determinations, the President contends the federal government is paying more for Medicaid eligibility determinations than it ought.\textsuperscript{18} This provision will reportedly reduce federal spending on Medicaid by nearly $1.8 billion over five years.\textsuperscript{19}

This reduction, while real, is slight in comparison with the administration’s proposed total outlay of $199 billion for Medicaid in FY 2007.\textsuperscript{20} It also constitutes only a small fraction of the total amount that the President proposes to shift from the federal government to the states in the President’s proposed 2007 budget.\textsuperscript{21} Having shifted some significant costs to beneficiaries in the 2006 budget, the administration appears now to have turned its sights to the states.

The problem is that the shifting of Medicaid expenditures ultimately constitutes a zero-sum game. Medicaid beneficiaries are almost uniformly impoverished, with workforce connections and/or physical conditions that significantly hamper their ability to obtain health insurance through private means.\textsuperscript{22} They need health care, but have little opportunity and ability to access it in the way that most Americans do. If the federal government does not pay for needed health care, then someone else must. Because of the impoverishment of most Medicaid beneficiaries, this means that states, local governments and/or health care providers are left holding the bag.

The need for health care does not stop just because one lacks insurance.\textsuperscript{23} If states cut eligibility to reduce expenses in light of cost shifting by the federal government, or if beneficiaries drop out of the program because they cannot afford new cost-sharing requirements or obtain necessary documents, then the cost of what little health care former beneficiaries can obtain must ultimately be borne somewhere. We must take a hard look at what constitutes responsible conduct with respect to the health care needs of our most vulnerable citizens.

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\textsuperscript{17} Office of Mgmt. and Budget (“OMB”), 2007 Proposed Budget, Dep’t of Health and Human Services, \url{http://www.whitehouse.gov/omb/budget/fy2007/hhs.html} (last visited Feb. 21, 2006).
\textsuperscript{18} Id.
\textsuperscript{19} Schneider et al., \textit{supra} note 16 (citing CMS Briefing Document, \textit{Medicaid and SCHIP: FY 2007 President’s Budget Proposals}).
\textsuperscript{20} OMB, \textit{supra} note 17.
\textsuperscript{21} Schneider et al., \textit{supra} note 16 (citing CMS Briefing Document, \textit{Medicaid and SCHIP: FY 2007 President’s Budget Proposals}).
\textsuperscript{22} For federal Medicaid eligibility baselines, \textit{see} 42 U.S.C. § 1396a(a)(1)(10) (West 2006).
\textsuperscript{23} \textit{See}, e.g., Jack Hadley & John Holahan, \textit{How Much Medical Care Do the Uninsured Use, and Who Pays for It?}, \textit{Health Aff. WEB EXCLUSIVE} (Feb. 12, 2003), \url{http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1} (last visited Jan. 31, 2006).