Commentary

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I'll try to be brief: We have a saying at my home base at the Rockefeller Institute that the ideal conference is nothing but coffee breaks where people can talk to each other about what they need to know, and I wouldn't want to interfere with that.

Being John Holahan and Alan Weil's discussant is a tough job; you basically want to say "what they said" and sit down. They've given you a pretty good overview of Medicaid's recent history and put forward some worthwhile ideas about where the program should be headed next. Rather than rehash what they've already told you, I'd like to spend a little time talking about Medicaid and health care politics and how they affect the choices federal and state governments are going to be able to make in the short run. Health policy in general and Medicaid in particular are as much political and institutional problems as they are intellectual ones, and what reforms get passed may be different from what you might like to see.

Viewed through this lens, there's not a lot of cause for optimism. The best sound bite description of the current Washington health policy landscape is "gridlock"—there's no clear sentiment in favor of trying to push health coverage or Medicaid in any particular direction, and most of the major proposals that have been put forward have attracted significant opposition. The Bush administration has resorted heavily to administrative devices—encouraging certain kinds of waivers, reducing the use of creative financing techniques, trying to eliminate graduate medical education—as its main means of Medicaid policymaking. The governors have been largely able to block Medicaid changes that they don't like—most recently, "block granting" Medicaid—but don't have a common vision for where they'd like to take the program beyond "give us more money and fewer restrictions." The most recent legislative success, if you want to call it that, was the Deficit Reduction Act, which didn't move Medicaid in any new directions, but rather gave the states more flexibility to do a lot of different things, which some of them are doing.

It's not clear this difficult situation is going to change very much going forward, even after the 2008 presidential election. It seems likely that the price of private health insurance and the number of uninsured will continue to increase. These trends will make health coverage a popular campaign issue—several presidential candidates already have proposals on the table—but there are several problems that may make major changes in Medicaid hard to achieve.

The biggest ones are Iraq and Afghanistan. The next president, no matter who he or she is, will inherit large, hot, expensive shooting wars in both those places, which will consume a lot of the available money and political capital. Second, to use a highly technical term, the federal budget is in the toilet and there are large multiple claims on resources. Even with a Democratic majority, Congress has been very grudging about smaller spending such as fully funding the State Children's Health Insurance Program and may well balk at the

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$45 billion to 50 billion in new spending that the authors want to hand them.

Third, states may be less well-off than they are now. States have had it pretty good for the past couple of years where Medicaid is concerned: Revenue growth has been solid, and the combination of the Medicare prescription drug benefit and slow enrollment growth has kept Medicaid spending growth, for this year at least, below the level of growth in state revenues. Some states even have put their own health reform proposals in effect and more are considering them.

While things are good for states right now, they may not be staying that way. My colleagues at the Rockefeller Institute who follow state finances have just reported that state revenue growth is slowing down. Particularly in wealthier states such as mine, state income tax revenue is driven by the stock market as much as by the overall economy, and state sales tax collections have become more unstable as many states have eliminated or reduced taxation on clothing and food. A slide in the stock market or an overall economic slowdown could make state revenue pictures look worse in short order.

This economic vulnerability may mean that states are not likely to be enthusiastic about the authors' proposals to make them spend money by expanding coverage for adults or cause them to lose money by eliminating or reducing creative financing techniques such as the Disproportionate Share Hospital Program or upper payment limits. Expanding coverage for adults is politically more difficult than for kids. The significant expansion in coverage for kids over the last 20 years has been one of the major success stories of the American public health insurance system: We do a much better job at covering kids than we once did, and disparities in coverage between states have narrowed dramatically. The politics were successful here—Southern governors were some of the earliest supporters of expanding eligibility for pregnant women and children, and, as Governor Thompson told you earlier, governors found it easy to campaign on doing things for kids, so states were competing with each other to expand coverage.

This model may not transfer well to adults. Kids are cute, popular, healthy, and cheap to cover; adults are not cute, not popular, more likely to be sick, and are decidedly more expensive. Even with the enhanced match proposed, covering adults to 100 percent of the poverty level or some other reasonable level will cost some states, particularly in the South, a lot of money that they may not want to spend.

So my prediction, which I'm making early enough for you to forget in case I'm wrong, is that we're *not* going to be able to pass major national changes in Medicaid anytime soon. What we might be able to do is make it easier for states to cover more adults and allow states to move ahead as they're able to, but large-scale changes in policy that call for spending a lot of money seem beyond our reach for the time being.