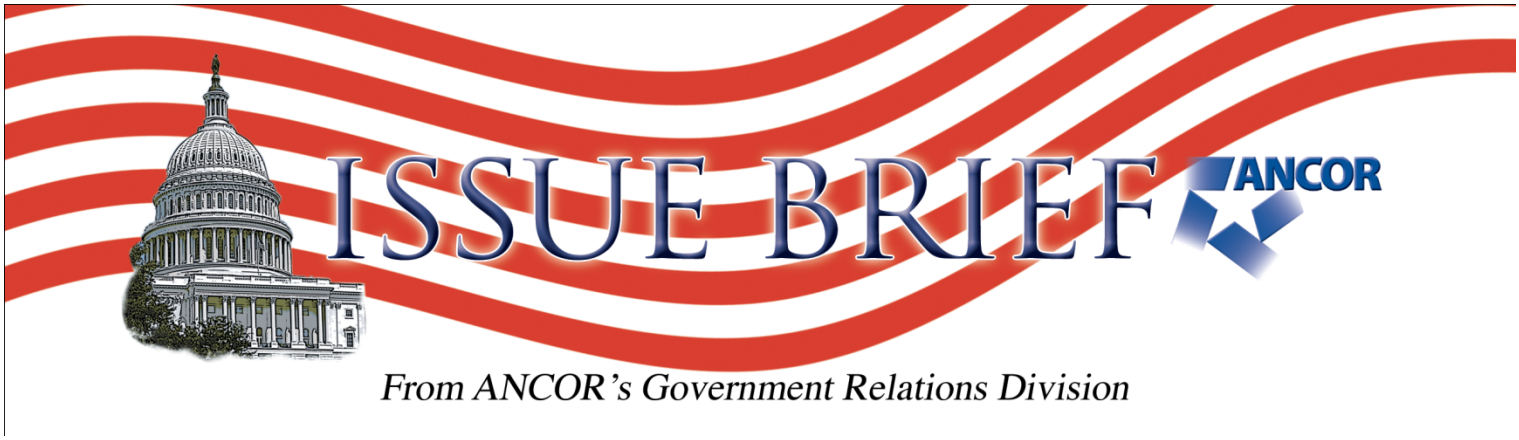

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ANCOR Issue Brief on Threats to Medicaid:

Converting Medicaid Into a Block Grant Unplugs the Existing Guarantees and Financing Design

With increased focus on the nation's deficit, growing national debt, and recurring state budget shortfalls, entitlement programs are under greater scrutiny. Congressional members and the Administration are putting forth proposals that will change and, in some, cases undermine the financing of Medicaid. This *ANCOR Issue Brief* on converting Medicaid into a block grant is the first in a series on Medicaid.

Since its inception in 1965, the federal government has helped states pay for the basic health care and long-term services and supports of low-income Americans in need. Currently, Medicaid pays for the costs of 39 million children and adults and 16 million low-income individuals with disabilities of all ages that need health care and long-term supports and services, making Medicaid the primary financing source of all coverage for long-term supports and services.

House Budget Chairman Paul Ryan (R-WI) unveiled a budget proposal on April 5 that included a proposal to block grant Medicaid. The House adopted that budget proposal on April 15. Senate Majority Leader Harry Reid (D-NV) has announced that he will bring the Ryan budget proposal to the Senate for a floor vote sometime after Congress returns after its two-week recess on May 2.

ANCOR strongly supports maintaining the current Medicaid entitlement approach and federal financing structure. A block grant would have negative implications for providers, beneficiaries, states, and localities.

ANCOR expects increased Congressional activity beginning in May up to and including a vote to increase the debt ceiling in early July. These proposals will come in many forms, including just a few of the following examples:

- **House Budget Chairman Paul Ryan's blueprint, The Road to Prosperity, which proposes a Medicaid block grant and the repeal of most of the new health reform law.**
- **President Barack Obama's April 6 comments that include replacing the current different federal matching rates for Medicaid and CHIP with a single rate, an automatic enhanced federal match rate and to initially reduce and then ultimately eliminate provider taxes.**
- **The "Gang of Six" Senators is expected to introduce their deficit proposal the week of May 2 that is expected to be based in part on the December 2010 report from the president's National Commission on Fiscal Responsibility and Reform.**
- **Vice President Joe Biden's deficit group that begins meeting May 5. The Senate Democratic plan due out in May may include a cap on federal funding.**
- **Senators Bob Corker (R-TN) and Clair McCaskill (D-MO) legislation to limit federal funding to 20.6 percent of the GDP.**

Review of Medicaid's Current Entitlement Nature and Financing Structure

It is important in first review Medicaid's current structure in order to understand the implications of a block grant. Knowing the basics of how the existing Medicaid will help providers assure that the public policy affecting the needs of people with disabilities are formulated soundly to meet the opportunities and challenges ahead.

There are five key things to keep in mind when discussing the Medicaid program:

1. Medicaid is an integral part of the health care system.
2. Medicaid spending is driven by enrollment growth and by spending for seniors and individuals with disabilities.
3. Medicaid brings in federal revenue to states and helps create jobs.
4. Medicaid increases access to health care and long-term supports/services using private providers.
5. The Medicaid expansion in health reform is projected to reduce the ranks of the uninsured by millions of people with the federal government picking up the vast majority of the cost.

Medicaid is a **means-tested individual entitlement** program that is **jointly financed by both federal and state governments and administered by state governments**. States administer their own Medicaid program consistent within broad federal guidelines.

Medicaid provides financing for a range of providers within communities across the country, supporting jobs, income and economic activity. The federal government matches state spending at least dollar for dollar for allowable state Medicaid spending. Consistent with the federal guarantee of Medicaid coverage for all eligible individuals, federal Medicaid matching dollars are guaranteed to states as needed.

According to the Kaiser Family Foundation, the Medicaid program now pays about $1 in every $5 spent on health care in the United States and $1 of every $2 spent on nursing-home care.

The federal medical assistance percentage (FMAP) is the share of total Medicaid expenditures the federal government pays (from 50 percent to 75 percent FMAP). The rate for each state is based on a formula set in statute based on a state's per capita income that provides relatively poorer states more federal assistance. This financing model allows federal funds to flow to states based on actual need—including spending on the enrollment of mandatory and optional beneficiaries, mandatory and options services and supports, provider reimbursement rates and a host of other decisions left up to each state.

Under the current financing structure, the federal government shares the costs of medically necessary health and long-term services and supports for low-income individuals—whether those costs rise or fall due to state policy decisions (raising or lowering provider payments rates) or whether they rise or fall due to factors outside of the state's control (e.g., growth in the eligible population, health care inflation, or national disasters).

This joint financing arrangement is designed to provide an incentive for states to commit resources to their Medicaid programs. With no cap on the amount the federal government pays to a state, the more a state spends, the more it receives from the federal government to reimburse a state for its Medicaid expenditures. This approach directs funding based on actual—rather than predicted—need. Demand for Medicaid increases when the economy is weak, requiring states to manage the increase in enrollment and program spending just as state budget conditions are most constrained.

Like all federal and state health care spending, Medicaid is subject to the same underlying cost drivers as the private sector. However, the Medicaid program has been able to control costs better than the private sector. The average cost per Medicaid beneficiary is significantly lower than private insurance after accounting for health differences, even with Medicaid's more comprehensive benefits and significantly lower cost-sharing. Additionally, Medicaid's costs per beneficiary have been growing more slowly in recent years than private insurance costs. The existing Medicaid program also provides federal funds to reflect the rise in medical costs.

During an economic downturn or disaster, unemployment rises, placing upward pressure on Medicaid. As individuals lose employer-sponsored insurance and incomes decline, enrollment and Medicaid spending increase. The existing Medicaid statute builds in this counter-cyclical quality.

The Ryan budget proposal's blueprint to create $1.4 trillion in Medicaid by converting the program to a block grant and repealing health reform represents a fundamental change in the entitlement nature and financing structure of the program. This change has major implications for Medicaid beneficiaries, providers, states and localities—as well as the ability of Medicaid to maintain its current roles in the health system.

To reiterate:

- **Medicaid provides an entitlement to coverage for individuals eligible for the program. States are not allowed to maintain waiting lists for mandatory services or enrollment caps on mandatory or optional beneficiaries.**

- **The federal government shares with a defined and predictable rate the costs of medically necessary health and long-term services and supports for low-income individuals—whether those costs rise or fall due to state policy decisions (raising or lowering provider payments rates or whether they rise or fall due to factors outside of the state's control, e.g., growth in the eligible population, health care inflation, or national disasters)**.

- **Medicaid guarantees states to federal matching payments with no cap to meet program needs.**

- **Medicaid currently fulfills other vital roles in the health care system (e.g., assistance to Medicare beneficiaries, medical education and safety-net hospitals and community health centers).**

- **Medicaid's guaranteed state financing with no caps supports state program choices (e.g., increases in provider rates and redesigning and rebalancing long-term services and support choices—some including enhanced federal match).**

Ryan and House Adopted Block Grant: You Think Your State Cuts In Medicaid Are Bad Now!

The budget proposal adopted by the House on April 15 would fundamentally restructure Medicaid. Under the Ryan plan, the Medicaid program would be converted into a block grant beginning in 2013. Instead of the federal government "picking" up a **fixed share** of each state's Medicaid costs (expenditures) as it does today, the block grant would provide each state with a **fixed dollar amount—with states responsible for all remaining Medicaid costs.**

- The total block grant amount available to states each year would **be based on the general population**(not on state's per capita income nor would the amount reflect changes in enrollment or specific segments of the population—e.g., the rising aging population).
- Typically Medicaid block grant proposals have set the initial grant allocation equal to actual federal Medicaid spending in the prior fiscal year and then annual adjustments.
- The amount for eac state would be adjusted annually by general inflation (i.e., by the annual percentage growth rate in the Consumer Price Index) plus the percentage growth rate in the size of the U.S. population—not the medical inflation index that rises faster the CPI).The annual adjustment, on average would be about **3.5 percentage points *less*** than the current projected growth rate for the Medicaid program over the next 10 years—a growth rate that would not take into account rising health care costs and an aging population. That gap would be as much as 4.8 percentage points in 2021.

In addition to eliminating the Medicaid expansion under last year's health reform law that is predominantly paid for with federal funds—leaving millions of individuals uninsured—it also would stand in the way of innovative programs

in the new health law to improve care for people on Medicaid and those with dual eligibility on Medicaid and Medicare. **The block grant plan would cut the current Medicaid program by $771 billion over the next 10 years (or 22.4 percent compared to current law).** It would cut federal Medicaid funding by 35 percent by 2022 and 49 percent by 2030, according to the independent Congressional Budget Office (CBO).

In exchange for the fixed state allotments, states would gain greater flexibility. However, the Ryan plan does not specify what the federal government would expect in return for the state allotment. It is also not clear if there would be a continued state match or if provider taxes would be affected or necessary as a source of state match. Currently the federal government pays, on average, 50% of a state's Medicaid administrative costs.

While CBO estimates that the Ryan block grant plan would indeed reduce federal spending and ratchet down the deficit and nation's debt load, the plan comes with a heavy cost—states, and by extension Medicaid beneficiaries and providers—would absorb more of the program's expenditures.

In order to make up this huge difference in federal funding reductions, states would have to provide substantially more state funding (raising taxes or cutting other state programs) or—and certainly more likely—cut back their Medicaid programs by substantially scaling back eligibility and services and continuing to cut provider reimbursement rates. Not only could current low-income access to needed health care and long-term services and supports be threatened, but more cuts in provider reimbursements could cause a range of providers to withdraw from Medicaid or close their operations.

If the block grant had been in effect starting in 2000, every state would have received substantially less from the federal government than it actually received under current law.

- **States where cuts would have topped 40 percent in 2009 include Arizona, Delaware, Hawaii, Idaho, Nevada, New Mexico and Oklahoma**.
- **States where cuts would have exceeded 30 percent include Alaska, Arkansas, California, Florida, Georgia, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, North Carolina, Ohio, Texas, Utah, Vermont, Virginia, Wisconsin and Wyoming**.

See the attached appendix for a Center on Budget Policy and Priorities estimate of state-by-state cuts if a block grant had been in effect in 2000.

While some governors are looking at ways to contend with the current economic crises and find ways to eliminate budget shortfalls by making various cuts in their Medicaid programs, a block grant and its fundamental shift in responsibility to states and other stakeholders is not the approach to take during a "temporary" imbalance in state spending and revenues. In fact, the past recessionary periods have shown just the opposite.

The current appeal of a block grant by some governors today cannot be reversed by a future governor. Nineteen Democratic governors have come out opposing the Ryan block grant proposal, while a handful of Republican governors have endorsed the Ryan proposal. However, many more of the 29 Republican governors have yet to sign on to the Ryan plan.

- **The trade-off in achieving predictable and reduced levels of federal financing and deficit reduction through a block grant would be the elimination of the entitlement to coverage and the guaranteed federal matching payments to states.**
- **A block grant with greatly reduced levels of federal financing would not reduce underlying program costs but would shift costs and risk to states, localities, providers and beneficiaries.**
- **Since a block grant would provide greater flexibility, it is unknown if the state would have to provide a defined, guaranteed and comprehensive package of health care coverage and long-term services.**
- **Converting to a block grant is a permanent decision by states and it is unlike approval of a time-limited waiver proposal by a state to redesign their programs. There is no going back with a block grant.**

Providers should point out the positive implications of the existing Medicaid program on page 3 compared to the above implications of a block grant

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Appendix Estimated Cuts If Ryan Medicaid Block Grant Had Been in Effect, 2000-2009 ($ millions)				
STATE	Reduction in Federal Funds, 2000-2009	Percentage Cut, 2000-2009	Reduction in Federal Funds, 2009	Percentage Cut, 2009
NATION	-$350,044	-21%	-63,531	-29%
Alabama	-4,517	-18%	-628	-20%
Alaska	-2,036	-36%	-260	-39%
Arizona	-18,735	-52%	-3,895	-66%
Arkansas	-6,033	-31%	-998	-39%
California	-35,259	-20%	-6,997	-31%
Colorado	-2,054	-15%	-478	-26%
Connecticut	-1,689	-8%	-751	-26%
Delaware	-1,393	-31%	-286	-45%
DC	-798	-9%	-260	-22%
Florida	-22,386	-32%	-3,054	-35%
Georgia	-12,152	-30%	-1,844	-36%
Hawaii	-1,752	-31%	-305	-41%
Idaho	-2,128	-31%	-371	-40%
Illinois	-9,303	-17%	-1,852	-27%
Indiana	-8,970	-28%	-1,349	-34%
Iowa	-3,825	-25%	-573	-30%
Kansas	-2,570	-21%	-434	-28%
Kentucky	-5,627	-19%	-1,126	-29%
Louisiana	-6,717	-19%	-1,235	-27%
Maine	-2,645	-21%	-545	-33%
Maryland	-5,323	-22%	-1,160	-34%
Massachusetts	-9,884	-21%	-2,173	-34%
Michigan	-5,868	-12%	-1,456	-22%
Minnesota	-7,190	-25%	-1,441	-37%
Mississippi	-6,784	-28%	-1,046	-34%
Missouri	-10,556	-28%	-1,851	-37%
Montana	-1,215	-25%	-208	-33%
Nebraska	-885	-10%	-122	-12%
Nevada	-2,205	-38%	-324	-44%
New Hampshire	-530	-9%	-101	-14%
New Jersey	-5,124	-12%	-702	-14%
New Mexico	-6,456	-38%	-1,220	-50%
New York	-24,901	-12%	-3,528	-14%
North Carolina	-13,802	-26%	-2,656	-37%
North Dakota	-346	-10%	-36	-9%
Ohio	-16,676	-25%	-3,094	-35%
Oklahoma	-5,705	-29%	-1,058	-40%
Oregon	-2,440	-13%	-622	-25%
Pennsylvania	-13,381	-17%	-2,170	-22%
Rhode Island	-1,475	-17%	-197	-19%
South Carolina	-5,129	-19%	-797	-24%
South Dakota	-623	-16%	-118	-23%
Tennessee	-9,653	-22%	-972	-20%
Texas	-20,063	-19%	-4,617	-32%
Utah	-2,210	-24%	-404	-34%
Vermont	-1,400	-27%	-269	-38%
Virginia	-5,624	-25%	-1,055	-36%
Washington	-4,557	-15%	-829	-22%
West Virginia	-2,013	-14%	-371	-20%

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West Virginia	-2,013	-14%	-371	-20%
Wisconsin	-6,867	-24%	-1,598	-40%
Wyoming	-572	-25%	-94	-32%

Source: CBPP analysis based on CMS Medicaid spending data. To determine states' block grant amounts under the Ryan proposal, we use federal Medicaid spending in 1999 as the base, adjusted annually by national population growth and the growth in the Consumer Price Index. We exclude federal Medicaid spending related to temporary federal Medicaid matching rate increases in 2003, 2004 and 2009.

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