

March 27, 2012

RYAN MEDICAID BLOCK GRANT PROPOSAL WOULD CUT MEDICAID BY ONE-THIRD BY 2022 AND MORE AFTER THAT

by Edwin Park and Matt Broaddus

The Medicaid block-grant proposal in the Ryan budget that the House of Representatives will vote on this week would cut federal Medicaid funding by 34 percent by 2022 (on top of repealing the health reform law's Medicaid expansion) because the funding would no longer keep pace with health care costs or with expected Medicaid enrollment growth as the population ages and employer-based health insurance continues to erode.

The magnitude of the plan's Medicaid cuts would grow still larger in subsequent decades. The Congressional Budget Office estimated last week that by 2050, the Ryan plan would cut combined federal funding for Medicaid, the Children's Health Insurance Program (CHIP), and the federal subsidies provided through the Affordable Care Act (to help low- and moderate-income people afford health insurance) by *more than 75 percent*, relative to current law.

Cuts of this magnitude would have substantial effects on the ability of millions of low-income Americans to secure health coverage and have access to needed health-care services. Medicaid cannot readily withstand cuts of this depth without large effects on low-income people. The program already costs significantly less per beneficiary than private insurance does, because it pays health providers much lower rates and has considerably lower administrative costs. In addition, its per-beneficiary costs have been rising more slowly than private insurance premiums for the past decade.

In fact, CBO has written that unless states increased their own Medicaid funding very substantially to make up for the Ryan plan's deep Medicaid funding cuts, they would have to take such steps as cutting eligibility (leading to more uninsured low-income people), cutting covered health services (leading to more underinsured low-income people), and/or cutting the already-low payment rates to health care providers, likely inducing more doctors, hospitals, and nursing homes to withdraw from Medicaid (and thereby reducing beneficiaries' access to care). Last year, when Chairman Ryan included a similar Medicaid block-grant proposal in his budget, the Urban Institute estimated it would lead states to drop between 14 million and 27 million people from Medicaid by 2021 (in addition to the 17 million people who would no longer gain coverage because of the repeal of the health reform law's Medicaid expansion).

How the Block Grant Would Work

Under the plan's proposal to replace Medicaid with a block grant, the federal government would no longer pay a fixed share of states' Medicaid costs.¹ States would instead receive a fixed dollar amount that would rise annually with the general inflation rate and the percentage increase in the size of the U.S. population.²

The Ryan plan does not provide much more detail about its Medicaid block grant proposal, but the proposal appears very similar to the block grant in last year's House-approved Ryan budget. Assuming the design specifications are the same as in last year's proposal (except for moving the block grant's start date back by one year, along with the base year used to calculate the initial state block grant amounts), each state would receive a fixed dollar amount starting in fiscal year 2014 that is set at the amount of federal Medicaid funding the state received in fiscal year 2011, adjusted for inflation and U.S. population growth since 2011.³ The block grant amounts for subsequent years would be based on the prior year's amount, adjusted for inflation and population growth.

Because the block-grant funding levels would not keep pace with health care costs or the expected increase in the number of Medicaid beneficiaries — especially the growth in the number of *elderly* beneficiaries, who cost more to serve — the block-grant funding levels would fall further behind need with each passing year. The percentage increase in the block-grant funding level from one year to the next would average more than 3.5 percentage points less per year than what CBO expects to be the Medicaid program's average growth rate over the coming decade under current law.

The Ryan budget would shrink federal Medicaid funding by \$810 billion — or 22 percent — over the next ten years, relative to current law (not counting the loss of the additional federal Medicaid funding that states would receive under the health reform law's Medicaid expansion, which the Ryan budget would repeal).⁴ By 2022, the federal Medicaid funding cut would equal \$163 billion for that year alone, a reduction of 34 percent compared to what states otherwise would receive for that year (see Table 1 for year-by-year estimates⁵). This percentage would grow larger each year after that.

These funding cuts would be even larger in years when enrollment or per-beneficiary health-care costs rise faster than is currently projected. Unlike under the current Medicaid program, where

¹ For background on Medicaid block grant proposals, see Edwin Park, "Medicaid Block Grants or Funding Caps Would Shift Costs to States, Beneficiaries and Providers," Center on Budget and Policy Priorities, January 6, 2011 and Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Shift Financial Risks and Costs to States," Center on Budget and Policy Priorities, February 23, 2011.

² Paul Ryan, "The Path to Prosperity," House Budget Committee, March 20, 2012.

³ The fiscal year 2011 Medicaid spending amount used for each state would exclude Medicaid expenditures related to the temporary increase in the federal Medicaid matching rate enacted as part of the Economic Recovery Act and the subsequent 6-month extension of that provision through June 30, 2011.

⁴ Under the Ryan block grant, the percentage reduction in federal Medicaid funding over 10 years would equal 38 percent, relative to current law, if the effects of repealing the ACA's Medicaid expansion are included.

⁵ CBPP analysis based on CBO baseline estimates. CBO similarly estimated that last year's House-passed block grant would cut federal Medicaid funding by 35 percent by 2022 relative to current law (after excluding the effects of repealing the ACA Medicaid expansion). See Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," April 5, 2011 and Edwin Park, "CBO Confirms Ryan's Medicaid Block Grant Would Likely Harm States, Beneficiaries and Providers," Center on Budget and Policy Priorities, April 6, 2011.

Table 1
Estimated Federal Medicaid Spending Cuts Required by Ryan Block Grant
 In billions of dollars

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2013-2022 |
|---|------|------|------|------|------|------|------|------|------|------|-----------|
| Federal Medicaid Baseline Spending * | 275 | 293 | 310 | 329 | 348 | 367 | 393 | 422 | 450 | 486 | 3,672 |
| Ryan Medicaid Block Grant Funding ** | n/a | 256 | 263 | 270 | 278 | 286 | 295 | 304 | 313 | 323 | 2,862 |
| Medicaid Spending Cuts under Ryan Block Grant | n/a | -37 | -47 | -59 | -70 | -81 | -98 | -118 | -137 | -163 | -810 |
| Percentage Cut | n/a | -13% | -15% | -18% | -20% | -22% | -25% | -28% | -30% | -34% | -22% |

*Excludes spending related to the Medicaid expansion under the Affordable Care Act, which would also be repealed.

**Assumes that the block grant is the same as the block grant included in last year's House-passed budget plan except for setting the start date and the base year one year later. The block grant would start in fiscal year 2014, and the initial block grant amount would equal fiscal year 2011 Medicaid spending (after excluding the temporary increase in the federal Medicaid matching rate provided as part of the 2009 Recovery Act and a subsequent extension of that provision), adjusted annually for the percentage increase in the Consumer Price Index and in overall U.S. population growth. Those annual adjustments also would apply for subsequent years.

Source: CBPP analysis using CBO baseline estimates. Figures may not sum due to rounding.

federal funding rises automatically in response to a recession or unanticipated costs from epidemics or medical breakthroughs, states would have to bear all such added costs themselves.

Under the block grant, states would be given expansive new flexibility in areas such as eligibility and benefits. CBO concludes, however, that while states may be able to use this flexibility to “improve the efficiency of those programs in delivering health care to low-income populations...the magnitude of the reduction in spending . . . means that states would need to increase their spending on these programs, make considerable cutbacks in them, or both. Cutbacks might involve reduced eligibility for Medicaid and CHIP, coverage of fewer services, lower payments to providers, or increased cost-sharing by beneficiaries — all of which would reduce access to care.”⁶ In other words, unless states come up with rather massive new sums to offset the very large losses in federal funding, they would be compelled to institute deep cuts.

States almost certainly would institute reductions in eligibility and/or coverage for beneficiaries and in payments to health care providers. These reductions would be deepest in periods such as recessions when the number of people in need of Medicaid increases at the same time that states face significant revenue declines and have the hardest time contributing any additional state funding. The cuts could include some or all of the following types of measures.

- States could cap Medicaid enrollment and turn eligible families and individuals away — in contrast to current law, under which all eligible individuals who apply must be allowed to enroll. The Urban Institute estimated that the similar Medicaid block grant in last year's House budget plan would cause states to shrink the number of low-income people receiving health coverage through Medicaid by between 14 million and 27 million people by 2021, which would constitute

⁶ Congressional Budget Office, “The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan,” March 2012.

an enrollment reduction of 23 percent to 46 percent.⁷

- Medicaid covers certain services typically not available through private insurance that are tailored to meet the needs of especially vulnerable beneficiaries — particularly low-income people with severe disabilities — who traditionally have been excluded from the private-insurance market. Such services, including case management, therapy services, and mental health care, are important for poor people with serious disabilities, but are expensive. Faced with very large federal funding cuts, states likely would curtail many of these services.
- The reductions in federal funding would likely cause many states to scale back coverage for low-income seniors and people with disabilities, especially coverage for long-term care. Low-income seniors and people with disabilities make up one-quarter of Medicaid beneficiaries but account for *two-thirds* of all Medicaid expenditures (because of their greater health care needs and because Medicaid is the primary funder of long-term care). This could mean that fewer seniors and people with disabilities with long-term-care needs would receive coverage for services and supports they need to remain in the community.⁸
- States also could charge low-income beneficiaries substantial premiums, deductibles, and co-payments. Medicaid currently ensures that coverage is affordable for low-income people by not charging premiums and keeping cost-sharing charges modest; research has found that premiums and cost-sharing lead many low-income households to remain uninsured or to forgo needed care. Under a block grant, however, states could begin charging substantial premiums, which could discourage enrollment. States also could begin requiring substantial deductibles and co-payments, which could prove unaffordable for some beneficiaries, including people with serious medical conditions that are costly to treat. This would reduce beneficiaries' access to care.
- States also could use the block grant to shift beneficiaries into private insurance, offering them a voucher to purchase coverage on their own. Since Medicaid costs substantially *less* per beneficiary than private insurance, however (largely due to its lower provider reimbursement rates and administrative costs, as noted above), shifting beneficiaries into private insurance would *raise* states' per-beneficiary costs unless the vouchers were set at levels that covered considerably fewer health services and treatments than Medicaid does today. Because the block grant would provide states significantly *less* federal funding, and private insurance costs substantially *more* per beneficiary, a state's adoption of a voucher system for Medicaid enrollees would likely result in fewer beneficiaries being covered or in beneficiaries being covered for substantially fewer health care services and treatments. Many of those who received a voucher could end up underinsured — lacking coverage for certain needed health care services or facing premiums, deductibles, or co-payments they could have considerable difficulty affording.
- States facing shrunken block-grant funding would likely scale back their provider reimbursement rates, which already are significantly lower than reimbursement rates under

⁷ John Holahan, *et al.*, “House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing,” Kaiser Commission on Medicaid and the Uninsured, May 2011.

⁸ See January Angeles, “Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities and Children,” Center on Budget and Policy Priorities, May 3, 2011.

Medicare and private insurance, and which have been cut substantially in recent years by states coping with budget shortfalls. The Urban Institute estimated that the similar block grant in last year's House-passed budget would result in reductions in reimbursements to health care providers of approximately 31 percent by 2021.⁹

These reductions in provider reimbursement rates likely would apply not only to hospitals, nursing homes, physicians, and pharmacies but also to managed care plans that currently serve low-income children and their parents through Medicaid and CHIP. That, in turn, could cause some providers and plans to stop serving low-income beneficiaries, which could jeopardize some beneficiaries' access to care, particularly in communities that already are medically underserved, such as rural areas. It also would place greater pressure on providers such as community health care centers and safety-net hospitals, which now rely on Medicaid funding but would likely face substantially increased patient loads, because of increased numbers of uninsured and underinsured individuals as a consequence of the cutbacks being made in Medicaid eligibility and covered services.¹⁰

Conclusion

House Budget Chairman Paul Ryan argues that his block grant proposal would allow states to tailor their Medicaid programs to better fit their needs and to provide Medicaid beneficiaries more choices and better access to care. Yet there can be no question that the block grant proposal would result in severe cuts in federal funding for state Medicaid programs. To compensate for funding cuts of this magnitude, states would have little choice but to institute deep cuts to eligibility, benefit coverage and/or provider payment rates. The almost inevitable result would be that millions more low-income individuals and families would end up uninsured or underinsured, with reduced access to needed medical care.

⁹ See Holahan, *op cit.*

¹⁰ See also Jesse Cross-Call, "Health Care Providers Would Face Deep Cuts in Payments and Higher Uncompensated Care Costs under Medicaid Block Grant," Center on Budget and Policy Priorities, June 28, 2011.