Protect Medicaid Series: Per Capita Caps/Block Grant Program Cuts

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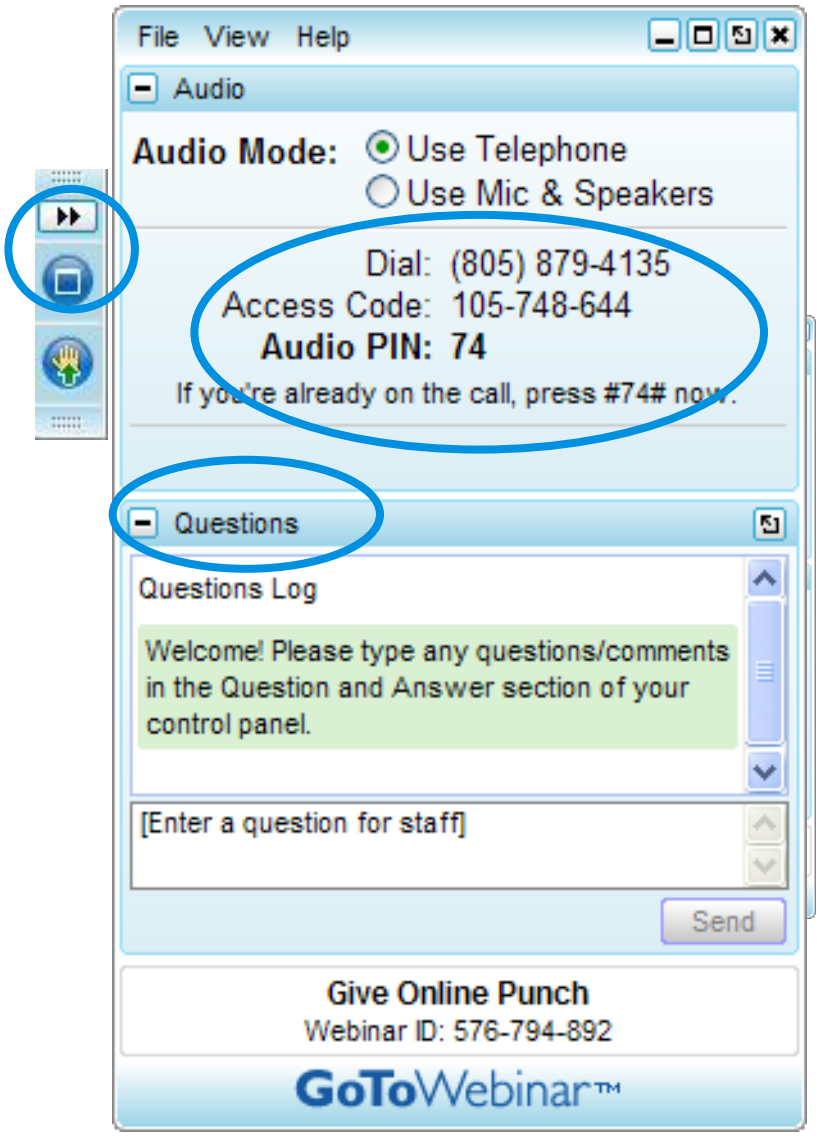
Housekeeping

GoToWebinar Interface…

- Maximize/minimize your screen with the chevron symbol
- Telephone participants need to enter their audio pin
- Please share your questions!
  - Ask a question in the questions log
  - Yes, we will make the recording, slides, and materials available



About NHeLP

- National non-profit law firm committed to improving health care access and quality for underserved individuals and families
- State & Local Partners:
  - Disability rights advocates – 50 states + DC
  - Poverty & legal aid advocates – 50 states + DC
- Offices: CA, DC, NC
- Join our mailing list at

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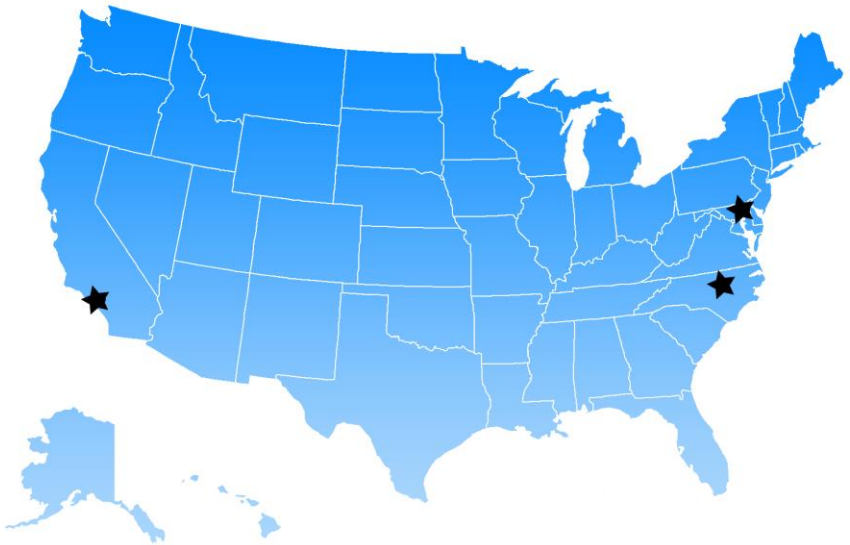

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Roadmap

- Medicaid's current financing
- Block grants/per capita caps
- Proposals pending on Capitol Hill
- Potential impact on low income individuals and families
- What you can do to protect Medicaid

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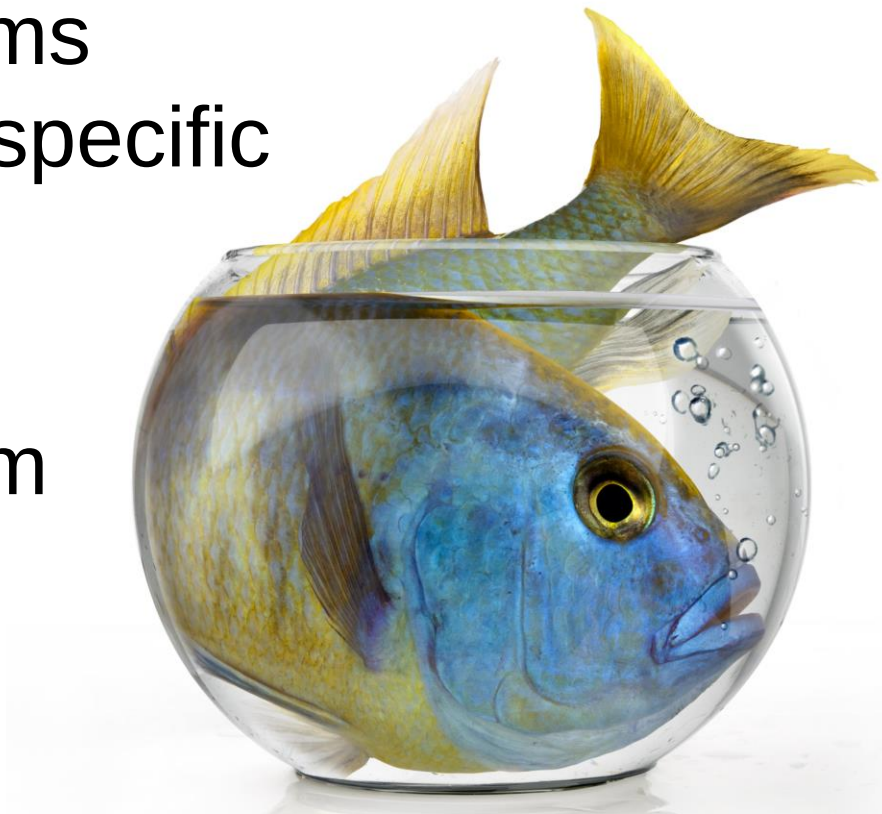
Medicaid is not “Discretionary”

- Discretionary programs are funded yearly at specific levels by legislative action
- Discretionary program funding can be cut and they can run out of money



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Medicaid is an "Entitlement"

- Mandatory programs are automatically funded at open-ended levels based on need
  - Can not run out of money

Current Medicaid financing

If your state wants to. . .	Do you get more federal $?
add more enrollees e.g. expansion, natural disasters, economic downturns	✓
add more services e.g. HCBS, ABA therapy, adult dental, family planning	✓
cover new Rx e.g. Solvaldi, Zika vaccine	✓
increase provider reimbursement	✓

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Other Medicaid features

- As an “entitlement,” Medicaid is a “property interest” under the Constitution and can’t be taken away without due process
- No waiting lists (except for some waiver programs)
- Federal-state partnership –
  - states pay part of the costs
  - on average 57% paid by the federal government but up to 75% in states with lowest per capita income
  - enhanced federal match for systems upgrades, services for newly eligible adults, family planning, preventive services

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Block grants

- Block grants eliminate the budgetary entitlement by setting a fixed allotment for each state
- Block grants put states at heavy risk for enrollment increases

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Per capita caps

- Theoretically, per capita caps solve the enrollment problem, by setting the cap per enrollee
- But per capita caps still leave states fully at risk for numerous other cost drivers

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Cost drivers PCCs ignore

- $ Medical innovations (ex. new Rx)
- $ New health conditions or pandemics (ex. HIV)
- $ Outbreaks (ex. Zika/flu)
- $ New health trends (ex. obesity, SUDs)
- $ Shifts in health demographics (ex. more aging enrollees)
- $ Natural disaster health impacts (ex. hurricane Katrina)

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Current financing v. block grants & per capita caps (in theory)*

If your state wants to. . .	Do you get more federal $?		
	Current Structure	Block Grant	Per Capita Cap
add more enrollees	✓	✗	✓
add more services	✓	✗	✗
cover new Rx	✓	✗	✗
increase provider reimbursement	✓	✗	✗

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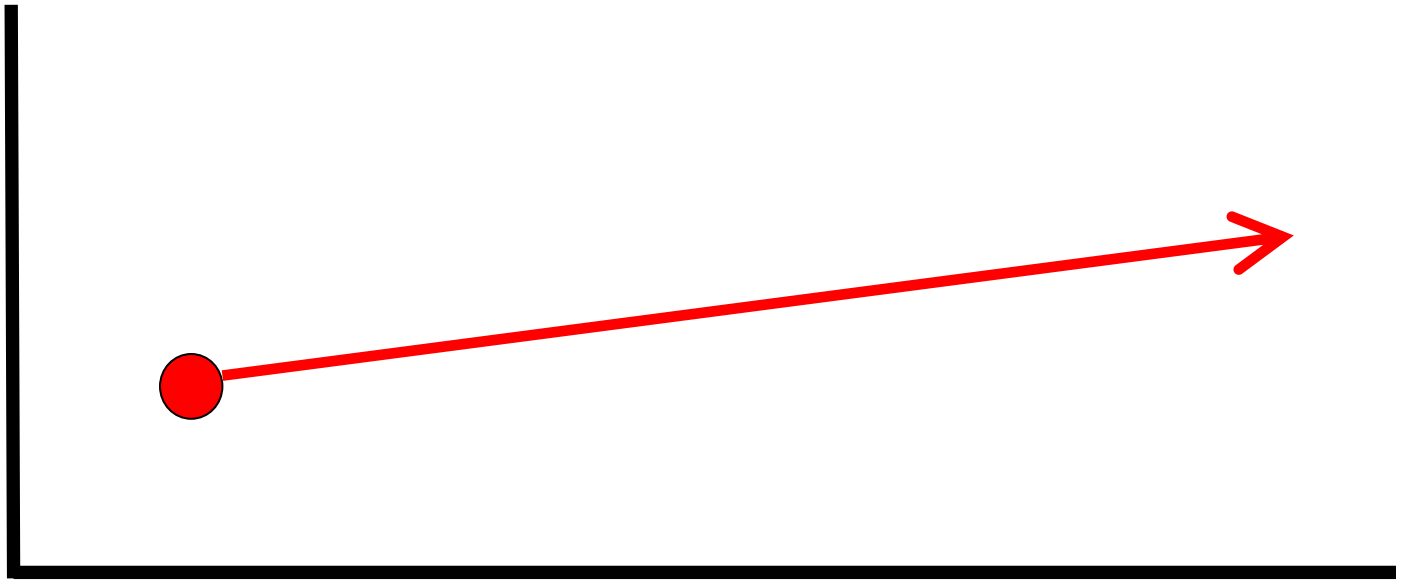
*This is theoretical since any proposal can alter a state's ability to add more enrollees or other features of the Medicaid program.

Designing a PCC

- First, a base year spending level is set
- Second, an index is used to set the yearly growth rate for the base spending level



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Base year spending level

- Some PCC proposals start with a base spending level below the current need
- State variability makes it hard to pick a base criteria that is fair to all
- Using past data to set base is problematic, but using future data lets states rig the game
- Will baseline be with or without Medicaid Expansion

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Index for growth

- Prior PCC proposals used growth indexes based on objective factors (such as CPI) that increase much more slowly and predictably than Medicaid spending
- They are also not counter-cyclical
- Ultimately they make the federal funding gap *grow* every year

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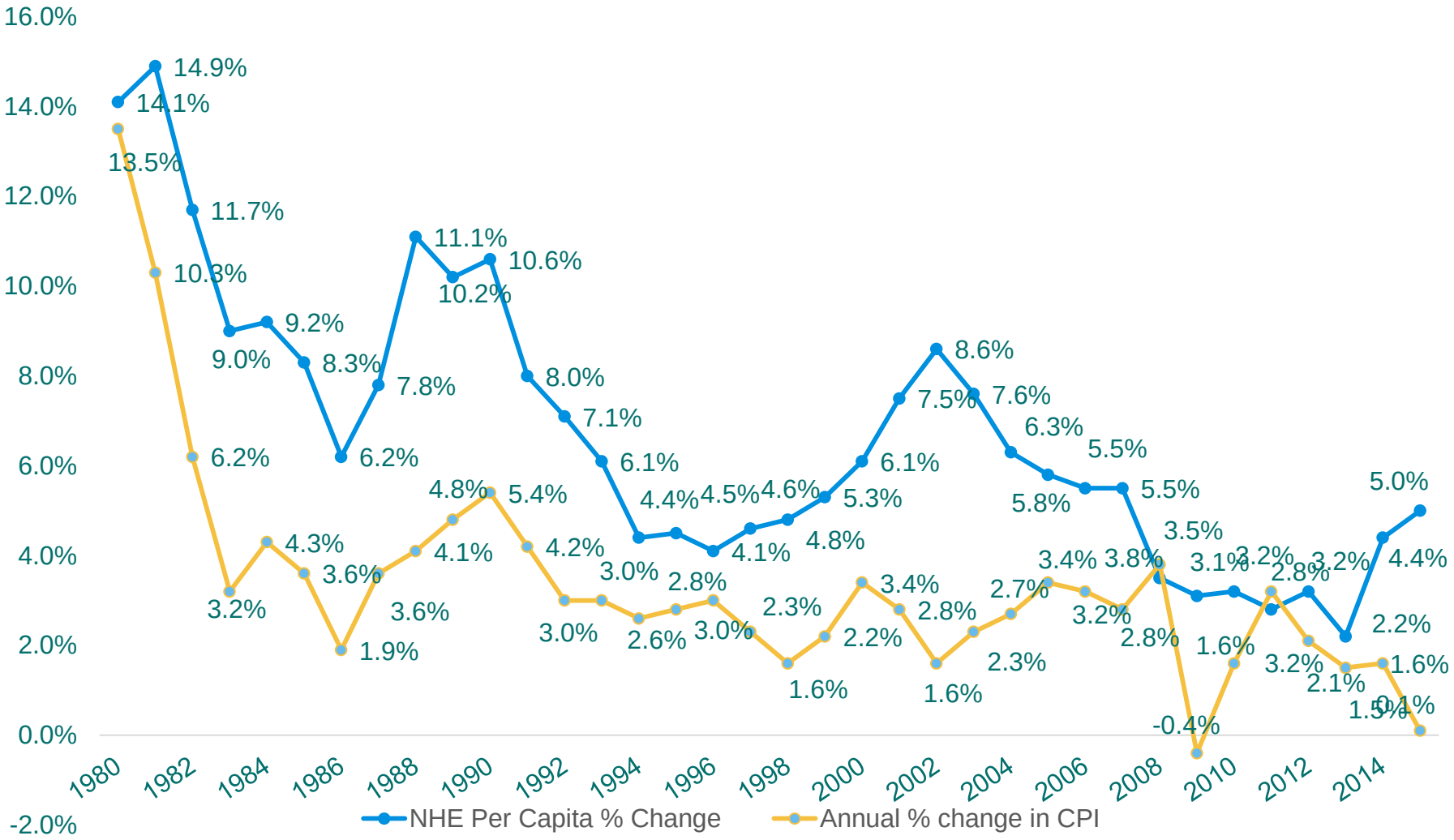
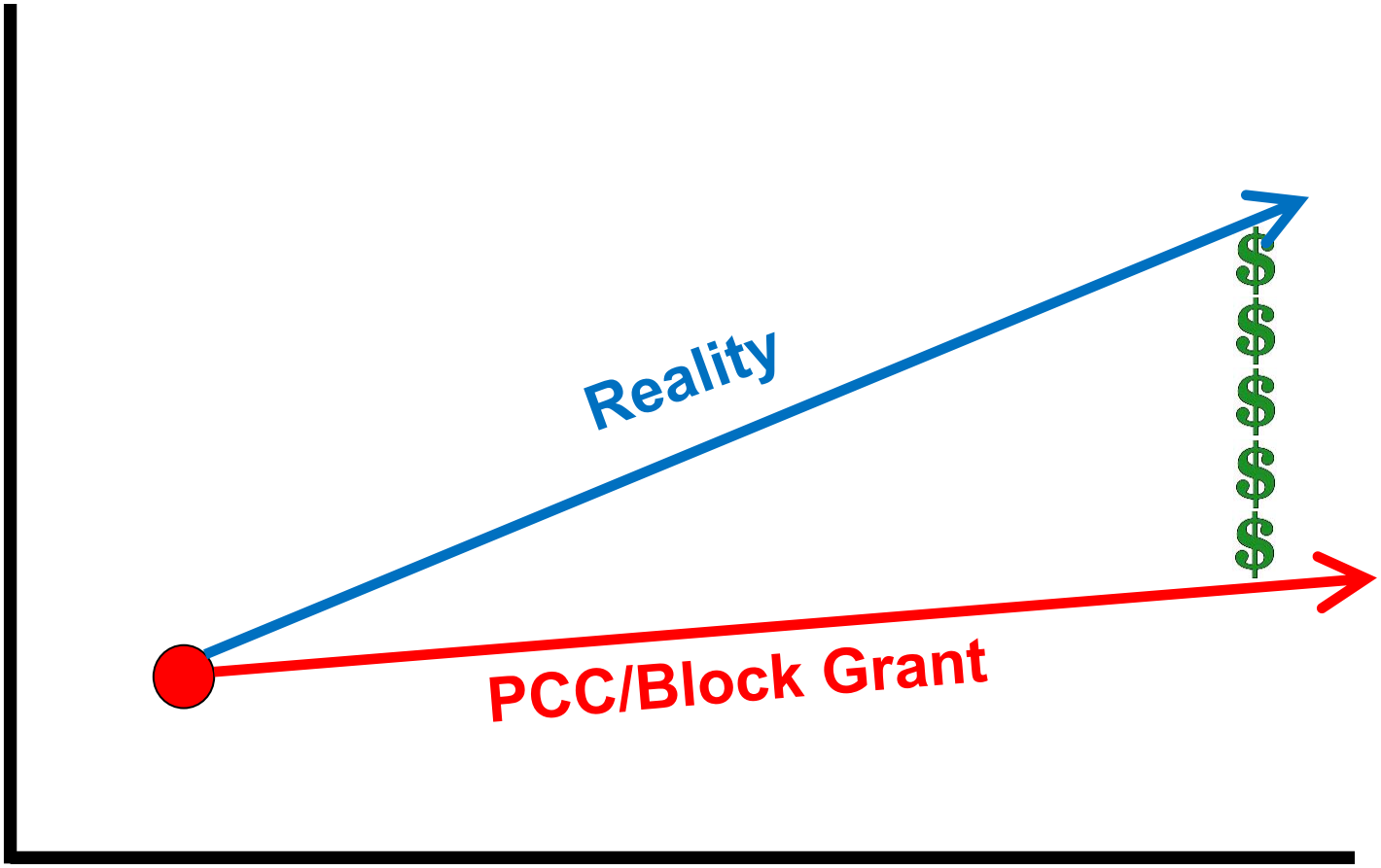
Growth in per capita health spending has consistently been higher than overall economic growth

Percent change in total health expenditures per capita, 1980-2015, Consumer Price Index 1980-2015



Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group and CPI data from Bureau of Labor Statistics at https://data.bls.gov/pdq/SurveyOutputServlet (All Urban Consumers, All Items, 1982-1984=100, Not Seasonally Adjusted, U.S. city average).

From bad to worse



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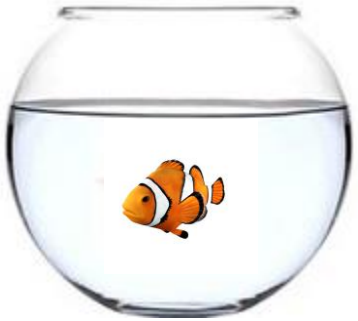
Design a PCC: Details

- Singular, combined cap creates problems

- Four caps design creates… different problems



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Medicaid Expansion Problems

- How will cap impact enhanced FMAP?
- Will expanders drop out or scale back?

- Will non-expanders stay away?

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A word about "flexibility"

- Medicaid is already flexible
  - Optional services and eligibility
  - Sec. 1115 waiver/demonstration projects
  - 60% of Medicaid spending is on optional services and eligibility
- Per capita caps/block grants shift costs onto states
- Cutting billions means less flexibility

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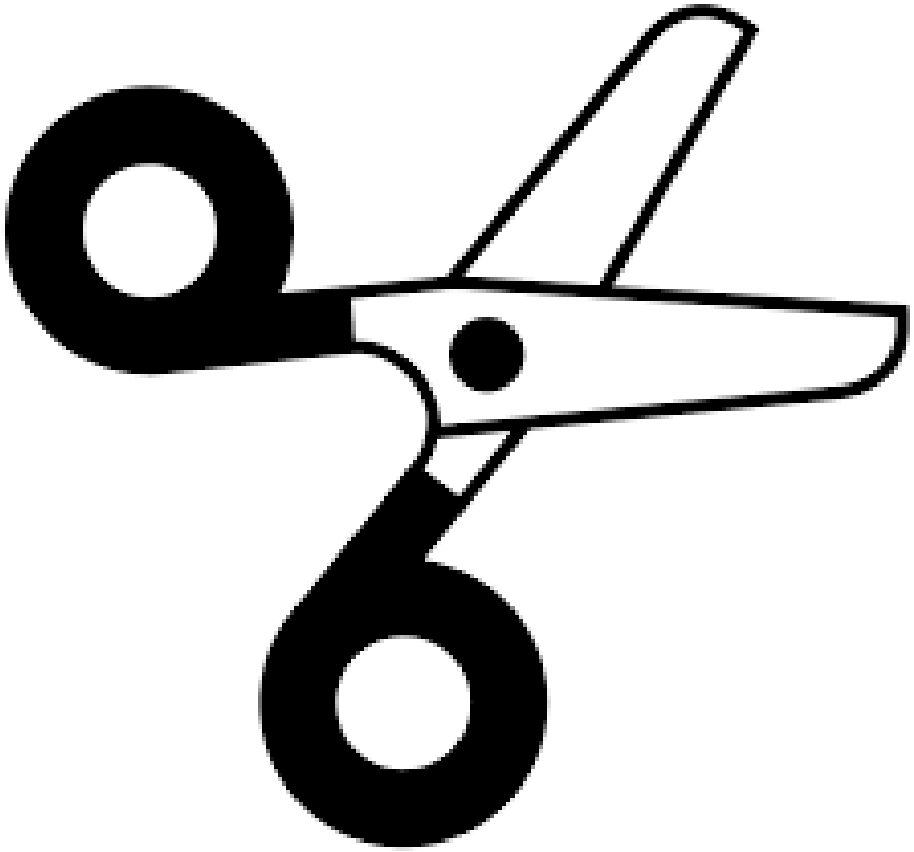
2012 Ryan Budget Proposal



- $810 B cuts via block grants
- $932 B cuts to Medicaid expansion
- 38% total decrease in spending ($1.3 T)
- 22% decline from pre-ACA spending

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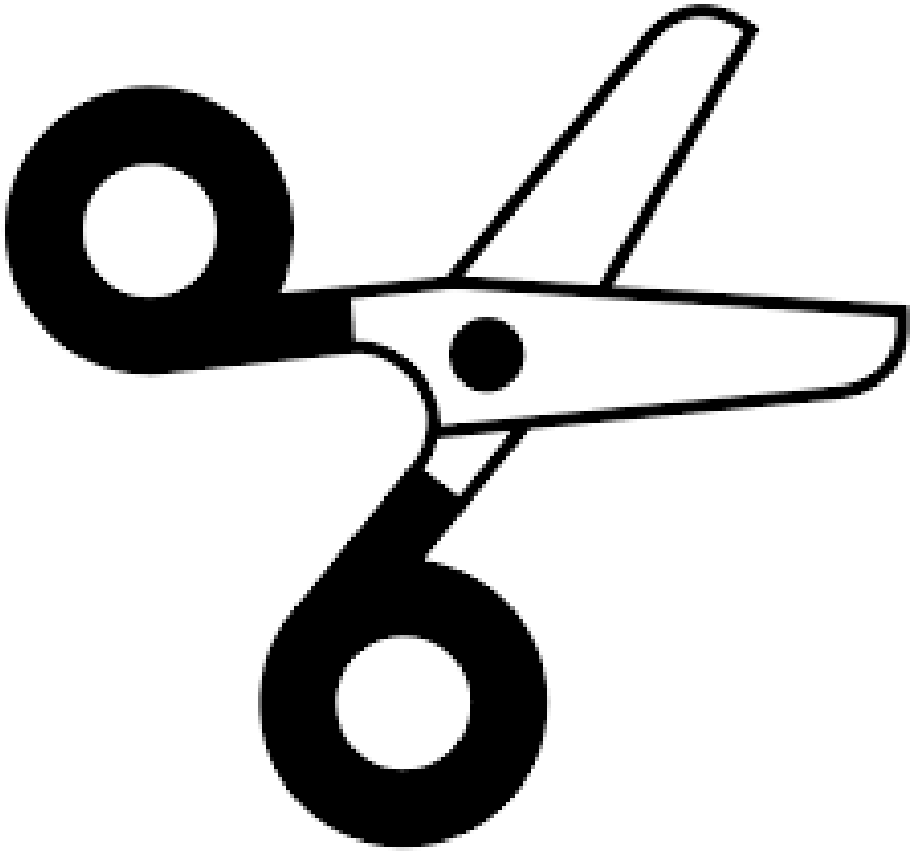
Source: Kaiser Family Foundation and Urban Institute, **National and State-By-State Impact of the 2012 House Republican Budget Plan for Medicaid**
http://kff.org/health-reform/report/national-and-state-by-state-impact-of

2012 Ryan Budget Proposal



- 14.5-20.3 million losing coverage (outside of MedEx)
- 25-35% drop in enrollment
- 30% drop in provider reimbursement

Source: Kaiser Family Foundation and Urban Institute, **National and State-By-State Impact of the 2012 House Republican Budget Plan for Medicaid**
http://kff.org/health-reform/report/national-and-state-by-state-impact-of

CBO on block grant proposal sim to 2012 Ryan plan

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, . . . coverage of fewer services, lower payments to providers, or increased cost-sharing by beneficiaries — all of which would reduce access to care.

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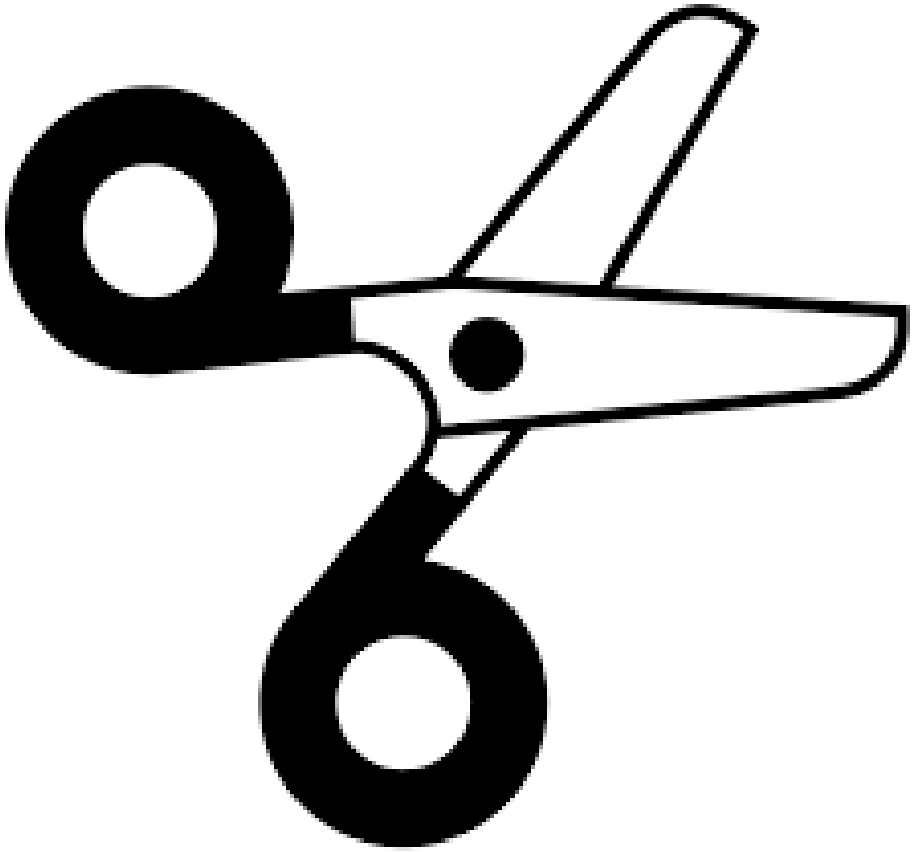
Source: Kaiser Family Foundation and Urban Institute, **National and State-By-State Impact of the 2012 House**

2016 Price Budget Proposal



- Block grant & repeal Medicaid expansion
- Cut $2.1 T/10 years
- Annual increase about 4.3% *less* than projected growth rate over 10 years
- **41 percent** less funding for Medicaid & CHIP in 10 years

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Source: House Budget Committee, Fiscal Year 2016 Budget, http://budget.house.gov/fy2016/ ; KFF, **5 Key Questions:**

House R's 2017 "Policy Brief"

- "Putting Medicaid on a Budget"
- Fully repeal ACA's Medicaid expansion
  - Allow continuation of current enrollees at enhanced FMAP for limited time
  - Future enrollees only regular FMAP
- Per Capita Cap – 4 categories (elderly, blind & disabled, children, adults)
  - Base year & index not specified
  - DSH, admin and unspecified "other" costs excluded from cap
- State option for a block grant or global waiver
- Reinstate DSH cuts

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A Cut is a Cut is a Cut!

- It doesn't matter what you call it – block grant, per capita cap, Medicaid reform
- The goal is still to CUT funding drastically and eliminate the entitlement

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Who or what gets cut?

- A lot depends on the legislative language and the parameters states must operate under
- Cuts likely targeted to more costly services and populations who need services the most:
  - EPSDT
  - People with serious or chronic health conditions
  - Costly treatments (Hep C, ABA therapy for kids with ASD)
  - Optional services (Rx, family planning)
- Could also cut provider reimbursements

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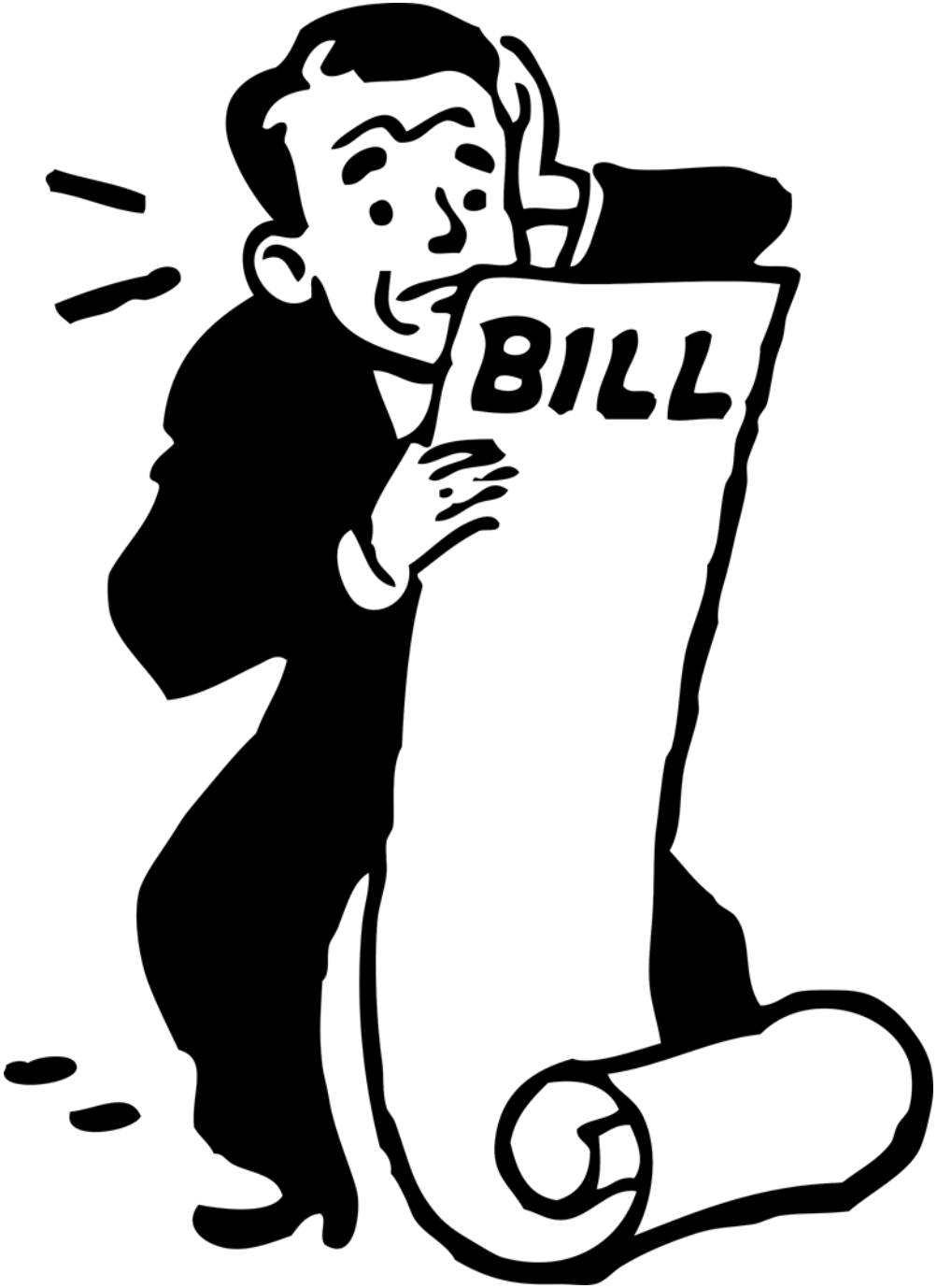
What's Next?



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Conclusions

- Changing financing to Medicaid radically alters the entitlement of the program
- Goal is to slash **billions** of dollars from Medicaid, not to make it more flexible
- Burden shifts to states to make tough decisions about eligibility, services, etc.
- States won't be able to be flexible if they don't have the $ to do it
- Affects enrollees, hospitals, insurers and providers – no one is safe
- Medicaid is different than CHIP

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What you can do

- Contact your elected representatives
- Work with state coalitions
- Prepare fact sheets and other materials (NHeLP is here to help)
- Story collection – Medicaid works!
- Mobilize, organize, resist

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THANK YOU

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