

Health Advocate

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Federal Medicaid Reductions: What's At Stake?

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Key Resources

Fact Sheets

- Understanding Medicaid Block Grants and Per Capita Caps: How Medicaid Currently Insures States, available [here](#).
- Medicaid Block Grants = Devastating Cuts to Health Care, available [here](#).
- Medicaid Cost Containment without Harming Beneficiaries, available [here](#).

Q & A

- Responding to Medicaid Cutbacks, available [here](#).

Coming in April's Health Advocate:

A primer on the use of Modified Adjusted Gross Income and Medicaid eligibility

Health care spending in the Medicaid program has the lowest level of spending inflation among insurers in the United States.¹ This is true because both state and federal budgeters have squeezed the Medicaid program for savings. For example, states have used Medicaid rate-setting authority to tightly limit the payments made to providers and keep the program's costs low.² States typically pay providers the bare minimum they are willing to accept – sometimes leading to access problems for enrollees. In short, Medicaid is the leanest health care coverage model in the nation.

Nonetheless, public and legislative misunderstanding about the cost of Medicaid has led to proposals to cut Medicaid, including efforts to block grant the program, implement per capita caps, reduce state provider assessments, and “blend” state matching rates. While each of these proposals has its unique problems, they share one fundamental flaw: they all attempt to “reduce Medicaid costs” by simply shifting more of the costs to states.³ The federal commitment to Medicaid spending is reduced, while states’ Medicaid participation responsibilities are unchanged—even as the population ages, poverty in America persists, and the costs associated with health care continue to climb. These proposals force states to address the *same or increasing* problems with *less* federal support.

Eventually, and predictably, reducing federal Medicaid commitments will lead states to be increasingly unable to meet the needs of their vulnerable residents, who include people with disabilities, the elderly, children, and pregnant women. Also predictably, states will take increasingly harsh steps to control their budgets. Below, we highlight four consequences of federal Medicaid funding reductions. The first concerns the special ways that reductions will harm Medicaid Expansion and Affordable Care Act (ACA) implementation. The remaining address ways in which states can be expected to cut their Medicaid programs if federal dollars are reduced.

¹ According to the Kaiser Commission on Medicaid and the Uninsured, “[t]he per enrollee cost growth in Medicaid (6.1 percent) is lower than the per enrollee cost growth in comparable coverage under Medicare (6.9), private health insurance (10.6), and monthly premiums for employer-sponsored insurance (12.6).” *Ten Myths About Medicaid*, Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/upload/7306%20ten%20myths%20about%20Medicaid_final-3.pdf.

² In fiscal year 2011, 39 states implemented reductions in provider payments. For fiscal year 2012, 46 states adopted (it is possible some won't be implemented) reductions in provider payments. See *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured (October 2011), available at: <http://www.kff.org/medicaid/upload/8248-ES.pdf>.

³ For a primer on block grants and per capita caps, see NHeLP's fact sheet and chart, *Understanding Medicaid Block Grants and Per Capita Caps*, available at: http://www.healthlaw.org/images/stories/NHeLP_Understanding_Medicaid_Block_Grants_and_Per_Capita_Caps.pdf

Medicaid Expansion and ACA Implementation Jeopardized

Federal Medicaid reductions will inevitably undercut implementation of the ACA's Medicaid Expansion. The possibility of reduced federal dollars, along with the "mixed message" and uncertainty signaled by federal wavering on the Medicaid commitment, has already been put forward as an excuse for some states to reject the expansion. Any actual federal Medicaid reductions will turn "ayes" into "nays" as fewer states will expand Medicaid. This will threaten the critical mass of 2014 implementer states necessary to demonstrate the value of the Medicaid Expansion and assure the long-term take up of the Medicaid Expansion. States that decline Medicaid Expansion will suffer from a "coverage gap" whereby wealthier Exchange individuals will be eligible for subsidies to purchase a Qualified Health Plan (QHP), while individuals below the poverty line are left with nothing, neither Medicaid nor subsidies. This will fuel discontent with the ACA and likely be exploited by opponents set upon repealing "Obamacare."

Cutbacks to Eligibility: Optional Populations

If federal Medicaid commitment is reduced, one option for states facing the dilemma of running a Medicaid program with less federal support is to reduce the number of people their Medicaid program covers.⁴ While they cannot eliminate mandatory populations that the Medicaid Act requires states cover, states can eliminate "optional" population groups even though they also desperately need health coverage. Broadly speaking, states can target optional groups in two ways:

1. By eliminating (or reducing) an optional coverage category. For example, all states have currently elected the option to provide Medicaid coverage to women in treatment for breast and cervical cancer. The state could eliminate it entirely.
2. By reducing a mandatory category to minimum levels. For example, since pregnant women are only a mandatory category up to 133% of the Federal Poverty Level (FPL), a state covering pregnant women up to 175% FPL could scale back coverage to 133% FPL.

It is true that the Medicaid Expansion and Exchange may reduce some of the negative impacts of these types of cuts, since some of the individuals impacted by a cut to an optional population *might* be eligible for the Expansion or Exchange subsidies. However, there are numerous reasons why this is not a solution to the problem. First, some states may *not* implement a Medicaid Expansion, and in those states the individuals cut would have no coverage if their incomes are below the FPL. Second, even if the state adopts a Medicaid Expansion, an individual transitioned from an optional category to the Medicaid Expansion or Exchange would likely see a reduction in needed health care benefits (Expansion populations receive commercially oriented "benchmark" coverage rather than the traditional Medicaid benefits) and an increase in cost-sharing requirements (which could be unaffordable).

One of the most disturbing aspects of optional eligibility cuts is that extremely vulnerable populations are likely to suffer. Individuals who are at risk include the elderly; persons with disabilities; women in treatment for breast or cervical cancer; special needs children in adoption and foster care systems; children with disabilities; individuals in need of home support services; and individuals in end-of-life care.

Cutbacks to Services: Optional Services

If federal Medicaid funding is reduced, states could also respond by cutting services.⁵ While states must cover a core set of mandatory benefits (physician and hospital oriented), they have the option to cover additional services (e.g.

⁴ States are generally prohibited from reducing eligibility for adults by a "Maintenance of Eligibility" provision in the Affordable Care Act until January 1, 2014. After that date, states will be totally free to cut optional eligibility.

⁵ In fiscal year 2011, at least 18 states implemented cuts to benefits (not including long-term care). In fiscal year 2012, 18 states adopted (but may not have all implemented) similar cuts. See *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured (October 2011), available at: <http://www.kff.org/medicaid/upload/8248-ES.pdf>.

prescriptions and community based services). If federal Medicaid funding is reduced, states may reduce their losses by eliminating the services available to Medicaid enrollees or reducing them to bare minimum levels.

One set of services that states are likely to target for cuts are home and community based supports that the elderly and persons with disabilities depend upon to stay healthy and live safely in their homes. Cutting these services will result in vulnerable seniors and persons with disabilities going without home attendants that keep them safe and take care of them. Even worse, many of these elderly or individuals with disabilities will be unable to safely remain in their homes and will be forced into institutions. This not only destroys their freedom and tears them away from their families and communities, but it is a long-term cost driver for the system to direct individuals into expensive institutional settings.

Reductions in Rates

Aside from cutting eligibility and services, a third way states might respond to federal Medicaid reductions is by cutting payment rates to providers. States might simply use their rate-setting authority in Medicaid to pay health providers less for the same services. While this is often the least harmful way for states to achieve Medicaid savings from the point of view of consumers, it can still have extremely negative consequences. Because Medicaid *already* has strong incentives for states to keep rates as low as possible, in recent years states have *already* reduced rates dramatically.⁶ And, because the rates are so low, Medicaid already faces challenges to maintain networks of providers willing to accept the low payment to treat individuals in need of care. There is little room to lower rates any further without serious and immediate consequences for consumers.

Conclusion

Attempts to reduce the federal commitment to Medicaid – such as through per capita caps or block grants – will have dire results. While legislators should look for ways to reduce Medicaid spending through improved preventive care and management of chronic conditions, any proposal which simply eliminates federal participation only *shifts costs* on to states and will have grave consequences: ACA implementation will be harmed, elderly people and persons with disabilities will be cut from Medicaid or see important services reduced or eliminated, and state health infrastructure will be threatened. These outcomes, though they may not show up in a CBO score, will ultimately be measureable in morbidity and mortality. The federal commitment to Medicaid must be maintained, and efforts should be made to find real *savings* through improved delivery of care.

⁶ See note 2.

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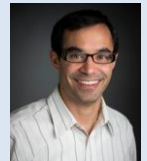
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