A Closer Look at the Threat to Medicaid

A series of fact sheets designed to help advocates understand how deficit reduction and the fiscal cliff threaten the future of Medicaid.

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Deficit Reduction: Tell Your Legislators to Protect Medicaid

Members of Congress are working on a plan to reduce the federal deficit. Several upcoming events are bringing this work into sharp focus: Absent Congressional action, in January 2013, automatic federal spending cuts will take effect and the Bush-era tax cuts will expire. Also, sometime around February, the debt ceiling will need to be raised again. What might be included in a deficit reduction plan is under negotiation. But one thing is clear: Medicaid is on the table.

Because negotiations are happening now, you should immediately tell your members of Congress that you know that deficit reduction is a priority for the President and Congress, but Medicaid should not be part of deficit reduction talks. We should not give tax breaks to the richest 2 percent by cutting programs like Medicaid that help our most vulnerable citizens.

Below we've outlined some points for evaluating deficit reduction proposals as they come out. But even before specific proposals emerge, you should be talking to your members of Congress, laying out these points, and letting them know what is and isn't acceptable in deficit reduction proposals.

Let your members of Congress know that these principles are essential to a fair and balanced deficit reduction plan.

▶ The proposal must include substantial revenue; it should not reduce the deficit through spending cuts alone.

An approach that is based on cuts alone is not balanced. A refusal to include revenue in deficit reduction is a guarantee of unnecessarily deep cuts in critical programs.[1] That approach will, of necessity, include deep cuts to health care programs that seniors and our most vulnerable citizens rely on, including Medicaid.

▶ The proposal should not make cuts to Medicaid.

Medicaid is a lean program with no administrative fat to cut.[2] There's not room to cut provider payments further, either: Those payments are already low. Further cuts could mean providers would be unwilling to participate in the program.[3] States, with their economies still recovering, cannot make up the federal Medicaid funds that would be lost.[4] Cuts to Medicaid will have to come out of health care spending by reducing services,

curbing eligibility, or both. That means cutting spending on nursing home care for seniors, home and community-based care for people with disabilities and seniors, and health care for children. Cuts in federal Medicaid spending simply pass costs on to states; to middle-class families; and to the seniors, people with disabilities, and low-income families who rely on Medicaid for health and long-term care.[5]

The proposal should not change the structure of Medicaid.

Today, anyone who meets Medicaid eligibility requirements in his or her state is entitled to Medicaid coverage. It is a true state and federal partnership. As state costs go up, federal support does, as well. That makes it easier for states to provide health coverage to everyone who qualifies. That also means that Medicaid's costs fluctuate. When the economy is better, fewer people need the program. But in recessions or during natural disasters, costs go up. This structure guarantees support when people—and states—need it. Changes to that structure fundamentally alter the nature of Medicaid. They make the federal partnership less reliable.

- Block granting Medicaid would give states a set amount of federal Medicaid funding that would not go up in times of economic hardship, natural disaster, or other events that might make health care costs or program enrollment increase. Under a block grant, if costs go up, states are on their own.
- Changing Medicaid to a per capita cap—a set federal payment per Medicaid enrollee—also leaves states holding the bag if health care costs rise.[6]
- Any kind of payment caps that include an inflation adjustment factor that is lower than medical inflation will end up passing more and more costs to states over time. That's because the value of the federal support won't keep up with increases in program costs
- Setting caps or targets also makes Medicaid an easy target for future cuts. Cuts can be accomplished simply by lowering the amount of the cap.

The proposal should not put full implementation of the Affordable Care Act at risk—cutting Medicaid will.

Proposals that cut Medicaid or change its structure will make it less likely that states will take up the Affordable Care Act's Medicaid expansion. The Medicaid expansion builds on the existing Medicaid program, and includes a promise of substantial federal support to help states extend coverage. Cuts to Medicaid or changes to the program draw that promise into question and make it less likely that states will elect expansion. The Affordable Care Act's goal of access to affordable health insurance for all Americans would be lost. We would be left with a health coverage program that leaves out many of our lowest-income citizens.

Medicaid should be excluded from any automatic cuts (sequestration).

There is a long congressional history of recognizing how critical programs for low-income individuals, such as Medicaid, are to people's very survival and of exempting those programs from automatic cuts that are part of deficit reduction legislation. The Gramm-Rudman-Hollings law of 1985 included automatic spending cuts to meet a deficit target, but it excluded Medicaid and other low-income entitlement programs from those cuts.[7] Today, the Pay-As-You-Go automatic cuts continue to exempt Medicaid and other low-income programs.[8] Medicaid was exempted from the automatic cuts in the Budget Control Act of 2011, the cuts scheduled to take place in January.[9] This is a tradition based on Congress's recognition that the millions who rely on these programs do not have the resources to turn elsewhere. Congress should not abandon this tradition.

Curbing Medicaid costs should be part of a thoughtful process of addressing overall health care costs.

As with Medicare and private insurance, rising health care costs contribute to higher Medicaid costs. Addressing health care costs should be part of a thoughtful process that doesn't randomly cut funding to meet a target, at the expense of people's health and productivity. That should include implementing the programs in the Affordable Care Act. Just cutting Medicaid doesn't make health care costs go away; it just passes them on to states and the people who depend on the program.

Medicaid is a reliable safety net for American's seniors, people with disabilities, and children. We should not balance our budget on their backs. Thoughtful, fair, and balanced deficit reduction won't cut Medicaid.

Endnotes

[1] Michael Leachman, et al., *Deficit-Reduction Package That Lacks Significant Revenues Would Shift Very Substantial Costs to States and Localities; Ryan Budget Cuts to State and Local Services Would Be Far Deeper than Cuts Under Sequestration* (Washington: Center on Budget and Policy Priorities, August 2012), available online at http://www.cbpp.org/cms/index.cfm?fa=view&id=3816.

[2] Robert Greenstein, *Romney's Charge that Most Federal Low-Income Spending Goes for "Overhead" and "Bureaucrats" Is False* (Washington: Center on Budget and Policy Priorities, January 23, 2012), available online at http://www.cbpp.org/files/1-12-12bud.pdf. In 2010, more than 96 percent of federal Medicaid spending went to pay for health and long-term care for enrollees, not administrative costs and overhead.

[3] Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan*, April 5, 2011, available online at http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf.

[4] Michael Leachman, et al., op. cit.

[5] Ibid.

[6] Families USA, *What's Wrong with Per Capita Caps in Medicaid* (Washington: Families USA, November 2012), available online at http://www.familiesusa2.org/assets/pdfs/medicaid/Per-Capita-Caps.pdf.

[7] *Compilation of Social Security Laws, P.L. 99-177, Title II - Balanced Budget and Emergency Deficit Control Act of 1985, Title II, Section 255(h)*, available online at http://www.ssa.gov/OP_Home/comp2/F099-177.html; Testimony of Paul N. Van de Water, Senior Fellow, Center on Budget and Policy Priorities, before the Committee on Finance, United States Senate, May 4, 2011, available online at http://finance.senate.gov/imo/media/doc/050411pvwtest.pdf. *The Balanced Budget and Emergency Deficit Control Act of 1985* exempted multiple low-income programs in addition to Medicaid.

[8] Public Law 111-139, February 12, 2010, *Public Debt Limit Increase, Title I-Statutory Pay-As-You-Go Act of 2010 (10)(d)(7)*, available online at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ139.111.pdf. The Pay-Go Act of 2010 exempts all of the low-income programs listed in the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) from sequestration. In addition, it exempts Medicare Part D low-income subsidies, Medicare Part D catastrophic subsidies, and Medicare cost-sharing for Qualified Individual (Q-I) premiums.

[9] Karen Spar, *Budget Sequestration and Selected Program Exemptions and Special Rules* (Washington: Congressional Research Service, October 2012), available online at http://www.fas.org/sgp/crs/misc/R42050.pdf.

FamiliesUSA
The Voice for Health Care Consumers

1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
Phone: 202-628-3030 ■ Email: info@familiesusa.org
www.familiesusa.org