Medicaid, the Budget, and Deficit Reduction: Keeping Score of the Threats

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As policy makers search for ways to reduce the federal budget deficit, conservatives are offering proposals that run the gamut from Rep. Paul Ryan's harsh Medicaid cuts to more innocuous-sounding "spending caps" or "global caps." While the mechanisms vary, the bottom line does not: All of these proposals would cut federal spending without reining in health care costs, so they end up cutting Medicaid and simply shifting costs to states, which will have no choice but to cut people or cut benefits—or both.

This is a crucial time for advocates to communicate with legislators about the need to protect Medicaid. And remember, it isn't enough to critique proposals—like the Ryan budget plan—that have been made public: Deficit reduction discussions are going on right now, with decisions being made behind closed doors. By the time we see some of these proposals, it may be too late to influence them. So let legislators know you oppose deep spending cuts, harsh caps on spending that could lead to deep spending cuts, and any proposal to restructure Medicaid into block grants.

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The Bottom Line: Our Message on Medicaid Cuts

- We agree that it's important to bring down the deficit.
- But the approach must be fair and balanced, with both spending cuts and revenue increases.
- And, whatever we do, we must not decimate crucial programs that seniors and their families, people with disabilities, children, and our most vulnerable citizens depend on.
- Medicaid is an efficient program, with little fat. Medicaid should not be cut—although we should look for savings that won't hurt beneficiaries.
- Medicaid is an invaluable tool when economic crises or natural disasters hit, with its ability to expand to take care of additional people when needed. We shouldn't change the structure of Medicaid.
- Simply cutting federal Medicaid funding is penny-wise and pound foolish. Less money to cover people means more visits to emergency rooms, sicker people, and overall higher costs for everyone, not savings.
- Backdoor mechanisms—like caps and triggers—can be just as harmful as Rep. Ryan's deep direct cuts unless Medicaid is exempted from automatic cuts.
- To bring down Medicaid spending, we must control health care costs. And to do that, we must fund and implement the Affordable Care Act.

The Lay of the Land

The threat to Medicaid comes from several directions, all under the rubric of deficit reduction. There are federal budget proposals for 2012 that make deep cuts to Medicaid spending—such as the House Republican budget proposal introduced by Rep. Paul Ryan (R-WI). That proposal would cut federal spending for Medicaid deeply over the next decade—slashing federal funding by one-third in 2021—and would change the program into a block grant.[1] Other proposals, such as the one laid out in legislation sponsored by Sens. Robert Corker (R-TN) and Claire McCaskill (D-MO) (known as the CAP Act of 2011, S-245), don't mention Medicaid at all but pose a threat to the program every bit as serious as that of the Ryan plan. The Corker-McCaskill proposal would place a permanent cap on federal spending that is significantly lower than current spending, with automatic program cuts if spending exceeds this cap. Given the level of spending cuts necessary to meet the Corker-McCaskill cap, it would be virtually impossible to avoid devastating cuts to Medicaid, cuts rivaling those outlined in the House Republican budget proposal. Under the automatic cuts in the Corker-McCaskill plan, one analysis estimates that federal Medicaid spending would be cut by $547 billion from 2013 through 2021; in 2021, federal Medicaid spending would be cut by 19 percent.[2] Even more proposals are now being debated and drawn up, many of them likely to follow the same framework: explicit, massive Medicaid cuts or spending caps that will require massive Medicaid cuts.

At the same time, we have reached the current limit on the national debt, which must be raised by the end of the summer. This is not an extraordinary event. A statutory limit was placed on the federal debt in 1917. Since then, Congress has frequently voted to raise the debt limit: As the economy grew, government's role changed, and dramatic events, such as World War II, required the government to raise money by incurring debt.[3] Just since 2001, Congress has voted to raise the debt limit 10 times.[4] Raising the debt limit is critical. Failing to do so would make it difficult for the government to fund federal operations, including paying interest on the existing debt. That could have potentially devastating effects on world financial markets.[5]

However, Republicans in Congress are using the critical debt limit vote as a bargaining chip to force draconian cuts in federal programs, including Medicaid. Vice President Joe Biden is leading bipartisan negotiations to develop a package that would combine a vote to increase the debt limit with a program for long-term deficit reduction. Other negotiations are happening behind closed doors. By the time the outline of a plan is clear, critical decisions about the fate of Medicaid and other health care programs will have already been made.

Medicaid Blended Rate Proposals

In addition to the proposals for global caps, block grants, and straight cuts to Medicaid, the Administration has proposed creating a "blended rate" for Medicaid as part of the deficit reduction talks. Like the other approaches we've outlined, this approach would shift costs to the states, making state Medicaid cuts inevitable. Our response is the same bottom line message.

Why a Blended Rate Equals a Cut

Today, the federal government pays a set percentage of each state's Medicaid costs. This payment is referred to as the Federal Medical Assistance Percentage, or FMAP. The percent varies by state, ranging from 50 to 75 percent. The Children's Health Insurance Program (CHIP) has its own federal matching rates, which also vary by state. In 2011, these rates ranged from 65 percent to just over 82 percent. (Some other programs and services also have different rates.)

The Affordable Care Act will expand Medicaid eligibility starting in 2014. In every state, from 2014 through 2016, the federal government will pick up 100 percent of the costs of covering newly eligible people. Over the following four years, the federal share will gradually decline to 90 percent, where it will remain.

While we don't know the details, presumably, a single "blended rate" would replace these different rates for Medicaid, CHIP, and the Medicaid expansion. To save money, that rate would likely be set lower than what a state would receive through the combined rates currently in place. With less money, there will be no winners—every state loses.

Although a blended rate might generate some very modest administrative savings, the real effect would be to shift costs to states. In addition, if states get a lower Medicaid match for people newly eligible under the Affordable Care Act, they will be less likely to conduct outreach and enrollment for this group. There will be other problems as well. For example, it will be difficult to calculate rates that are accurate and not challenged by states. Finally, this is an administrative approach to finding "savings" that can easily be manipulated. So, if budget negotiators find that they have come up short, it may be tempting to turn to Medicaid and say, "if we just lower that blended rate a bit…," thereby passing more costs on to states and low-income individuals and families.

Like the other proposals, creating a blended rate doesn't deal with underlying health care costs—it simply cuts federal funding and puts states and vulnerable citizens on the line.

Evaluating the Proposals

With all of these moving pieces, different budget proposals surfacing every week, and critical debt ceiling negotiations happening outside of the public eye, it is difficult to know what to focus on in your advocacy and even harder to keep track of what proposals are good, which are bad, and which are even worse. Below, we've outlined four questions that you should ask when assessing how any proposal might affect Medicaid. These questions, and their answers, all interrelate in the way that deficit reduction proposals will ultimately play out and affect the future of Medicaid. You should evaluate any proposal on the table against all four of the questions below.

1. Does the proposal get to the target solely by reducing federal spending?

If yes, it isn't a balanced approach. It will, of necessity, need to include deep cuts in the larger health care spending programs, including Medicaid.

- There are two ways to reduce the deficit: cutting spending and raising revenue. Raising revenue can include increasing tax rates, imposing new taxes, or eliminating tax loopholes or deductions. A refusal to include any revenues as part of the deficit reduction plan is a prescription for unnecessarily deep cuts in critical programs. That's true whether the plan is based on a cap on all federal spending, a cap on only health care spending, a deficit or debt target, or any other mechanism. Unless both spending and revenue are part of the equation, it is unlikely that Medicaid could be excluded from cuts. Unless both are part of the equation, it is unlikely that any proposal to exclude Medicaid from cuts would be sustainable.

2. Does the proposal make deep cuts in Medicaid?

If yes, then Medicaid would likely be turned into a block grant.

- The House Republican plan cuts Medicaid by one-third in 2021 and explicitly converts Medicaid into a block grant. Even if a proposal does not explicitly convert Medicaid into a block grant, if it includes deep Medicaid cuts, Medicaid would almost certainly be converted into a block grant program. That is because the only way to ensure that federal Medicaid spending could predictably meet a radically lower level than today—or than projections under current law—would be to restructure the program and convert it to a block grant. Because Medicaid is an entitlement program—meaning that anyone who qualifies is entitled to benefits—under its current structure, it is impossible to guarantee that spending will stay within a specified limit. The only way to make Medicaid costs predictable is to change the structure of the program from an entitlement to a block grant. With a block grant, once the funding limit is reached, states can simply say, "Tough luck" to low-income people who seek health care or long-term care.

- Block grants are generally touted as a way to save money, but in fact, they only save federal money. Because most federal block grant allocations do not keep pace with inflation in health care costs, even a block grant that seems sufficient in the first year will soon fall far short of needs. States will be left holding the bag and will have to either come up with additional funding or cut people, benefits, provider reimbursements, or all three. What's more, giving states carte blanche to decide who is covered and what benefits they get will likely leave our most vulnerable citizens at the mercy of state politics.

3. Even if the proposal doesn't seem to cut Medicaid, does it have across-the-board caps, cuts, or targets?

If yes, then Medicaid will certainly face deep cuts.

- The population is aging, and with that, spending on health care, including Medicaid as the major payer for long-term care, will rise. Proposals that reach deficit reduction through deep spending cuts—by capping all federal spending, capping health care spending, or reaching a deficit target through severe spending cuts—will force deep cuts in Medicaid. Medicaid and CHIP make up approximately 8 percent of federal spending.[6] Proposals that require significant cuts in federal spending most likely cannot meet their goal without steep cuts to Medicaid, cuts so dramatic that the program would need to be converted into a block grant to provide the government with cost predictability. A deficit reduction approach based on radical federal spending cuts to meet a target does not deal with the costs of health care, but simply passes those costs down to states and consumers.

4. Does the proposal have an automatic enforcement mechanism, and does this mechanism apply to Medicaid?

If yes, across-the-board spending cuts would happen automatically, unless Congress passed legislation to reduce spending enough to meet the target. And Medicaid would be subject to potentially crippling spending cuts.

- Automatic enforcement, sometimes called a trigger or funding sequestration, means that federal spending cuts would happen according to a formula unless federal spending met, or fell below, the spending target. With automatic enforcement, members of Congress would not need to make hard decisions, take hard votes on cuts, or be forced to reach agreement. In many proposals, these automatic cuts would be difficult to avoid. In the Corker-McCaskill proposal, for example, automatic enforcement could only be waived or suspended with a two-thirds vote in both the House and Senate.[7]

This approach does not leave Congress with flexibility to be responsive as emergencies arise or as public needs change.[8] In the case of Medicaid, for example, the government would not be able to increase support to states in the event of an economic downturn that increases Medicaid rolls. Today, as more people need Medicaid during a downturn, federal support increases. This funding mechanism not only helps people have access to the health care they need, but plays a stabilizing role in the economy. Over time, as automatic cuts keep taking big bites out of the program while an aging population's need for Medicaid to help cover long-term care costs grows, the gap between federal support and the need for care will get wider and wider. States will have to pick up an increasingly larger Medicaid tab, or pass an ever-growing financial burden onto seniors and their families.

- There is a long congressional history of recognizing how critical low-income programs, such as Medicaid, are to people's very survival and of exempting those programs from automatic enforcement mechanisms in any deficit reduction legislation. Congress should not walk away from that tradition. 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.[9] Today, the Pay-As-You-Go automatic cuts continue to exempt Medicaid and other low-income programs.[10] 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. Refusing to exempt programs like Medicaid abandons that tradition. It would limit Medicaid's role as a reliable safety-net for more than a quarter of American's seniors and people with disabilities and, with CHIP, nearly one out of three children.[11] There is little "fat" to spare in the Medicaid program, where rates of per capita increases in spending have been below the rates of other payers.[12]

Messages for Decision Makers

Right now, all members of Congress are thinking about the budget and the debt ceiling vote. Even if you don't have a particular proposal to talk about, it is important that you let your members know your position.

- Let them know that you realize that it is important to reduce the federal deficit over the long-term, and that includes controlling health care spending.
- The approach to deficit reduction should be sustainable, should balance spending reductions with revenue raising measures, and should not decimate programs that seniors and their families, people with disabilities, children and our most vulnerable citizens depend on.
- Medicaid and other low-income entitlement programs should be exempted from any mechanisms for automatic cuts, such as caps or triggers that set cuts in motion if targets are not met.
- Medicaid is an efficient program, with little fat to spare. It should be spared from cuts.
- Controlling health care spending should be part of a thoughtful deficit reduction process that focuses on better care delivery, not just making massive federal spending cuts and passing costs on to states and consumers. The Affordable Care Act established a framework for making lasting improvements in health care delivery by reining in spending and increasing coordination of care.

Deficit reduction is important, but its price should not be putting an end to any modicum of health care security for millions. It should not be done through an approach that puts the country into a financial box that makes it difficult for the government to make appropriate, or even critical, spending adjustments in the future. A balanced approach that couples spending reductions with revenue increases, that takes the long view of controlling, rather than just slashing, health care costs, can get us there. A truly balanced approach could even get us there while protecting the programs like Medicaid that are vital to so many.

Endnotes

[1] Families USA, *House Republicans Propose to Slash Funding For Medicaid, Medicare, and Other Health Coverage Programs* (Washington: Families USA, April 2011), available online at http://www.familiesusa.org/budget-battle/House-Republicans-Slash-Health-Coverage-Funding.pdf.

[2] Edwin Park et al., *Proposed Cap on Federal Spending Would Force Deep Cuts in Medicare, Medicaid, and Social Security* (Washington, Center on Budget and Policy Priorities, April 2011), available online at http://www.cbpp.org/files/4-14-11bud.pdf.

[3] Mindy Levit, *The Federal Debt: An Analysis of Movements from World War II to the Present* (Washington: Congressional Research Service, September 2010), available online at http://www.fas.org/sgp/crs/misc/RL34712.pdf. In nearly every year since the establishment of the country, the U.S. government has accumulated debt. The percent of gross debt as a percentage of gross domestic product (GDP) was at its peak in 1946, after the unprecedented spending required by World War II.

[4] D. Andrew Austin, *The Debt Limit: History and Recent Increases* (Washington: Congressional Research Service, May 2011), available online at http://www.fas.org/sgp/crs/misc/RL31967.pdf.

[5] Mindy Levit et al., *Reaching the Debt Limit: Background and Potential Effects on Government Operations* (Washington: Congressional Research Service, April 2011), available online at http://www.fas.org/sgp/crs/misc/R41633.pdf. The debt limit was reached on May 16, 2011. For a limited time, the Treasury Secretary can use strategies to handle cash and manage the debt without disrupting government operations; however, those strategies cannot be used indefinitely.

[6] Center on Budget and Policy Priorities, *Policy Basics: Where Do Our Federal Tax Dollars Go?,* updated April 2011, available online at http://www.cbpp.org/files/4-14-08tax.pdf. Medicare, Medicaid, and CHIP combined accounted for 21 percent of $3.5 trillion in federal spending in 2010. Medicare, Medicaid, and CHIP combined accounted for $732 billion, with Medicare making up $452 billion of that amount and Medicaid and CHIP the remainder, or $280 billion, approximately 8 percent of the total. (Families USA calculation.)

[7] S. 245, CAP Act of 2011, Section 316(b). The CAP Act is available online at http://thomas.loc.gov/cgi-bin/query/z?c112:S.245: .

[8] Testimony of Robert D. Reischauer, Director of the Congressional Budget Office, before the Subcommittee on Legislation and National Security, Committee on Government Operations, U.S. House of Representatives, May 13, 1993, available online at http://www.cbo.gov/ftpdocs/103xx/doc10382/1993_05_13reischauertestimony.pdf. In his testimony, Mr. Reischauer discussed the problem with deficit reduction enforcement processes that dictate severe automatic cuts.

[9] *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; and, *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.

[10] *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.

[11] Dee Mahan et al., *Cutting Medicaid: Harming Seniors and People with Disabilities Who Need Long-Term Care* (Washington: Families USA, May 2011), available online at http://familiesusa2.org/assets/pdfs/long-term-care/Cutting-Medicaid.pdf; Jocelyn Guyer, "The Ryan Budget Resolution: Implications for Children's Coverage," *Say Ahhh!*, A Children's Health Policy Blog sponsored by Georgetown University Center for Children and Families, April 6, 2011, available online at http://theccfblog.org/cgi-bin/mt/mt-search.cgi?blog_id=1&tag=Paul%20Ryan&limit=20. Medicaid and CHIP combined cover close to one in three children.

[12] John Holahan et al., *House Republican Budget Plan: State by State Impact of Changes in Medicaid Financing* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2011), available online at http://www.kff.org/medicaid/upload/8185.pdf. From 2000 to 2009, Medicaid per-enrollee spending was slightly above the increase in the Medical Care consumer price index, but well below growth rates in national health expenditures, both overall and per capita, and employer-sponsored premiums.

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