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Assessing the American Health Care Act's Medicaid Policy

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In assessing efforts to repeal and replace Obamacare, policymakers should evaluate the American Health Care Act's (AHCA) Medicaid provisions for their capacity to address problems created by Obamacare and to offer new and better options for the poor served by the program.[1] Medicaid is a welfare program, jointly financed by federal and state governments. The Obama Administration simply expanded the program, even though it has a comparatively poor record of providing patients' access to care and achieving acceptable medical outcomes.[2]

As currently designed, Medicaid is an open-ended federal entitlement. As the Congressional Budget Office (CBO) explains, "All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated."[3] Under the current Medicaid payment formula, the federal government finances between 50 percent and 75 percent of Medicaid costs, depending upon the circumstances of the various states. The average federal Medicaid payment, according to the CBO, is 57 percent.

Obamacare created a newly eligible population under Medicaid: able-bodied adults with an income equal to or less than 138 percent of the federal poverty level ($27,821 for a family of three, in 2016 dollars). The compulsory feature of the Medicaid expansion was originally a mandate on the states. In 2012, the Supreme Court struck it down as unconstitutional. Since then, states have had the option of expanding coverage and securing additional federal dollars for the coverage of these new enrollees. Under Obamacare, the "expansion states" that enrolled these newly eligible persons received certain federal matching rates:

- For 2014 to 2016, the rate was 100 percent;
- After 2016, the expansion states then get a reduced match rate for their "expansion population" of 95 percent in 2017;
- In 2018, the rate is 94 percent;
- In 2019, the rate is 93 percent; and
- In 2020 and thereafter, the rate is 90 percent.

The AHCA would make three major changes to the Medicaid program.

1. Impose a cap on Medicaid spending;
2. Provide states with the option of taking federal Medicaid payment as a block grant; and
3. Set in motion a reversal of the Obamacare's Medicaid expansion.

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Capping Medicaid spending is a critical entitlement reform. The block grant proposal, although an improvement over current law, needs refinement for specific populations, while an alternative approach—premium support—would empower able-bodied recipients to enroll in private health plans. Finally, the rollback of the Medicaid expansion is too slow and needs work.

Medicaid Provisions in AHCA

The Cap. The AHCA would cap the Medicaid entitlement. Instead of an open-ended system of federal financing, the House bill would set payment to the states on a per capita basis (effective in fiscal year (FY) 2020) for general Medicaid spending. The capped payment would be based on *average cost* per enrollee. Medicare dual-eligible enrollees (poor and disabled persons securing benefits under both the Medicare and Medicaid programs) would be excluded from reimbursement calculations under the new per capita payment system. The CBO estimates that Medicaid spending reductions would amount to $880 billion over 10 years.[4]

The bill sponsors set the base year for determining new Medicaid payment at 2016, adjusted over the period 2016 to 2019 for the general Medicaid population by the medical component of inflation, or the medical consumer price index (CPI), which is more generous than the conventional inflation indices.[5] In 2020 and thereafter, Medicaid spending would be indexed by the medical CPI plus 1 percent for the aged, the blind, and the disabled.[6] Under the terms of the bill, the states would be free to spend more than the federal payment in the administration of Medicaid benefits and services; however, they would finance the difference if they did.

The bill would tighten accountability for the use of federal dollars by giving the Secretary of Health and Human Services (HHS) the authority to reduce the annual growth of the federal government's Medicaid contribution to the state by 1 percent if the state does not submit required performance data on its Medicaid spending. The bill would also repeal Obamacare's "essential benefit" requirements for Medicaid, thus giving state officials more flexibility in the management of the program.[7] The bill would also require eligibility redeterminations every 6 months for the acute care population.[8]

The Block Grant. Effective in FY 2020, the bill allows states the option of securing Medicaid payment through a block grant of 10 years' duration.[9] The funding is limited to financing the care of poor adults and children, but not to the newly eligible Medicaid enrollees who have signed up for Medicaid coverage under the expansion. Funding for the elderly, the blind, and the disabled would not be included in the block grant option.

1. The American Health Care Act of 2017, H.R. 1628, 115th Cong., 1st Sess., is a 124-page bill to repeal and replace key provisions of the Affordable Care Act. It was reported out of the House Rules Committee on March 21, 2017, for House floor and later Senate action. The legislation emerged from the deliberations of four major House committees: Ways and Means, Energy and Commerce, Education and Workforce, and the House Budget Committee. A "Manager's Amendment" has also been included for the House Rules Committee that makes specific changes not included in earlier versions of the legislation. There are, in fact, two sets of Manager's Amendments, one focused on technical changes and the other on policy changes. For purposes of this *Issue Brief*, they are referenced as the *Manager's Amendment*.
2. For a review of the professional literature on the subject, see Kevin D. Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 9, 2012, http://thf_media.s3.amazonaws.com/2012/pdf/bg2740.pdf.
3. Congressional Budget Office, "Cost Estimate of the American Health Care Act," p. 10, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf (accessed April 12, 2017).
4. Ibid., p. 6.
5. In 2011, as part of a comprehensive debt reduction and entitlement reform proposal, The Heritage Foundation proposed a capped federal Medicaid allotment to the states, adjusting the Medicaid cap by the medical CPI. See Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity* (Washington, DC: The Heritage Foundation, 2011), p. 28, http://savingthedream.org/about-the-plan/plan-details/SavAmerDream.pdf.
6. The American Health Care Act, §121, as modified by the *Manager's Amendment*. This is slightly more generous than the earlier version of the bill, which would have indexed the Medicaid spending growth by medical CPI.
7. Ibid.
8. Ibid., §116.
9. Ibid., §121, as modified by the *Manager's Amendment*.

For a state to secure a block grant, the HHS Secretary must approve the state's plan for using the funds. A state plan would be deemed to be automatically approved unless the Secretary determines that the plan is "incomplete or actuarially unsound." The grant payment formula would include a calculation of the state's number of Medicaid enrollees and the per capita medical assistance expenditures for the covered categories of enrollees. Block grants would be indexed to inflation, as measured by the CPI, and the funds can be rolled over from year to year. States getting block grants would be required to contract with an independent auditor to oversee the use of the funds. The Secretary would have access to the auditor's findings.

Limiting Extra Funding for Expansion. The bill re-designates the Obamacare Medicaid expansion population (childless, non-elderly, non-disabled, non-pregnant adults) as an optional population that states may cover at normal match rates. States that already expanded coverage to those individuals will continue to receive the higher Obamacare match rate for those who were enrolled in the program prior to the end of 2019 and remain enrolled.[10] Starting in 2020, federal funding for this population would also be subject to the proposed per capita cap or the alternative block grant funding reforms.

The bill also permits, but does not compel, states to impose a work requirement on newly eligible enrollees as a condition for securing Medicaid coverage. Any work requirement would apply only to non-disabled, non-elderly, and non-pregnant Medicaid recipients.[11] While not the focus of this analysis, work requirements for the Medicaid program, unlike other welfare programs, are likely to be unworkable or difficult to administer and enforce, as reported by Heritage Foundation welfare analyst Robert Rector.[12]

Improving the Medicaid Provisions

The AHCA's Medicaid general payment policy is a major entitlement reform. Analysts have long proposed putting Medicaid on a budget and capping state allotments, while giving states greater managerial flexibility in the administration of the program.[13]

The AHCA block grant proposal needs refinement for specific Medicaid populations, while premium support would better serve able-bodied recipients.

The Medicaid expansion provisions need work. The AHCA retains the extra funding for Obamacare Medicaid expansion longer than necessary. That encourages expansion states to continue enrolling able-bodied individuals into the program, which further crowds-out limited Medicaid resources for the more vulnerable populations, such as poor children and the disabled, whom Medicaid was created to cover in the first place. For improving the Medicaid provisions, there are two better policy options:

- **Replace the block grant with a robust Medicaid premium support program.** Congress should fund assistance to the *able-bodied* Medicaid population in the form of a direct defined contribution—a premium support program—for enrollment in private health plans. This would mainstream these enrollees into competitive private insurance coverage along with their fellow citizens, thus giving them access to the same networks of doctors and medical professionals and stable and superior medical care, particularly crucial primary care.[14] Too many Medicaid enrollees still rely on emergency room care because they cannot find a doctor to take care of them.

  On the other hand, a Medicaid block grant option makes sense for the Medicaid disabled and long-term-care populations, as long as the states have broad administrative and managerial flexibility to better address the particular demands of these complex and difficult patient populations.[15]

10. Ibid., §112, as modified by *the Manager's Amendment*.
11. Ibid., §117, as amended by the *Manager's Amendment*.
12. Robert Rector, "Work Requirements in Medicaid Won't Work. Here's a Serious Alternative," The Daily Signal, March 17, 2017, http://dailysignal.com/2017/03/17/work-requirements-in-medicaid-wont-work-heres-a-serious-alternative/.
13. See The Heritage Foundation, *Blueprint for Reform: A Comprehensive Policy Agenda for a New Administration in 2017*, Mandate for Leadership Series, 2016, p. 55, http://thf_media.s3.amazonaws.com/2016/BlueprintforReform.pdf.
14. See The Heritage Foundation, *Blueprint for Balance: A Federal Budget for 2017*, Mandate for Leadership Series, 2016, pp. 8–9, https://thf-reports.s3.amazonaws.com/2016/BlueprintforBalance.pdf.
15. See Butler, Fraser, and Beach, *Saving the American Dream*, p. 28.

- **Accelerate the reversal of the Obamacare Medicaid expansion.** Congress should limit Obamacare's higher federal match rate to those in the expansion population enrolled in the program before July 1, 2017. From that date onward, states should receive only the standard match rate for new expansion population enrollees. Starting in 2020, the House bill authorizes an entirely new Medicaid payment system for states, which would also apply to the expansion population. If Congress instead created a new premium support program for able-bodied Medicaid recipients, it could also determine income eligibility for a defined contribution to allow for those recipients being enrolled in private health plans.

Conclusion

Capping Medicaid spending is a critical entitlement reform and secures enormous taxpayer savings. While the block grant option for the Medicaid population is an improvement over the current system, a far superior alternative would be the creation of a Medicaid premium support program for the able-bodied Medicaid population. Reserving the block grant option for the disabled and long-term-care populations, which need more intensive and innovative management and state oversight, is a far better step. The AHCA's rollback of the extra funding in Obamacare for Medicaid expansion to able-bodied adults is unnecessarily slow and generous to the expansion states, while consuming resources better directed to the traditional, more vulnerable Medicaid populations.

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