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Medicaid: How the Senate's Reforms Would Retarget Federal Funding for America's Most Vulnerable Citizens

Robert E. Moffit, PhD

The Senate Republicans' Better Care Reconciliation Act of 2017 (BCRA), which would partially repeal and replace Obamacare (also known as the Affordable Care Act, or ACA), would make major changes in the Medicaid program. The Senate bill pursues three major policy objectives. Specifically, the BCRA:

- **Undertakes a major reform of the Medicaid entitlement.** The Senate bill does this by changing the program's financing. It would slow the growth of federal Medicaid spending, and federal payments would no longer be on autopilot. This would advance federal entitlement reform by using an approach that has enjoyed the support of liberals and conservatives alike.[1] There is widespread recognition in the health policy community that reform of federal entitlements is essential in order to reduce deficits and debt and thus reduce the financial burdens on current and future taxpayers.

- **Targets Medicaid funding to the beneficiaries who most need assistance.** The bill targets Medicaid resources to the most vulnerable Medicaid recipients. Nothing in the bill would change the mandatory requirements to cover certain Medicaid population groups or limit the amount of government funding to any individual eligible for mandatory Medicaid coverage; states would be free to increase Medicaid spending to any levels they think desirable. For persons who are ineligible for Medicaid, the bill expands federal assistance through a revamped health insurance premium tax credit. It also authorizes funding for the states to provide direct assistance to these low-income persons in the individual private insurance market, including those previously covered by Medicaid, to offset the costs of their health insurance premiums and their out-of-pocket medical costs.

- **Allows state officials greater administrative authority to manage their own Medicaid populations.** Under the Senate bill, states not only would have greater authority to manage their Medicaid programs, but also would be able to secure fast-track waivers for managed care Medicaid programs and home and community-based programs, as well as get federal bonuses for improving the quality of care delivered to Medicaid beneficiaries.

These changes would accompany a reversal of Obamacare's Medicaid expansion, which spends taxpayer money on a new class of enrollees, most of them childless adults who can work, rather than the most vulnerable populations that the program was designed to serve: the disabled, elderly, children, and pregnant women in poverty. As Galen Institute Senior Fellow Doug Badger has noted, Obamacare's

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The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
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expansion "fundamentally changed Medicaid from a program that established eligibility only for poor people who fell into certain categories (low-income children, pregnant women, people with disabilities, and frail elderly people) to one that established eligibility for people solely on the basis of income."[2]

Under the Senate bill, the federal government would refocus spending on the disabled, elderly, children, and pregnant women in poverty by targeting federal spending to Medicaid's traditional populations based on their enrollment and average levels of spending. Moreover, states will also have more power to restructure their Medicaid programs in ways that work best for them.

The Medicaid Challenge

Medicaid is a welfare program that provides free care to its beneficiaries. The federal and state governments jointly administer Medicaid and provide medical care and social services to the disabled, elderly, children, and pregnant women in poverty. Traditional Medicaid recipients also include those needing long-term care.

Under the current formula, federal payment covers between 50 percent and 75 percent of a state's Medicaid costs for these traditional Medicaid beneficiaries. Federal taxpayers are currently responsible for about 57 percent of state Medicaid costs on average. The elderly and the disabled account for well over half of all Medicaid spending.

Under Obamacare, states can expand Medicaid benefits to a new class of adults, including childless adults who can work, with an annual income up to 138 percent of the federal poverty level (FPL). Obamacare provided generous federal payments to cover these newly eligible persons, most of whom are childless able-bodied adults. From 2014 through 2016, the federal payment for these enrollees was 100 percent of the cost. In 2017, the federal payment is 95 percent of the cost; in 2020, it will be set at 90 percent. Thirty-one states and the District of Columbia have expanded Medicaid, taking advantage of the higher federal payments.

Federal payments are "open-ended," which means that if a state spends more on Medicaid, federal payments to the state to cover the state's costs are automatically increased. Medicaid is now the nation's largest health program, enrolling 77 million persons, with federal spending projected to increase from $368 billion to $655 billion over the next 10 years.[3] The program has expanded far beyond its original goals: For example, Medicaid funds the costs of approximately 45 percent of the nation's births.[4] It also is growing faster than the general economy or inflation. The Government Accountability Office (GAO) routinely lists the program as "high risk"; in 2015 alone, "improper payments" amounted to $30 billion in Medicaid spending.[5] The program is clearly in desperate need of reform.

What the Senate Bill Does

The major change in policy is the manner in which the federal government would send payments to the states. This would occur in two ways: a per capita payment system or a new block grant payment, with the choice left up to the states. Whatever choice the states make under this new federal payment regime, they would be free to add more of their own funds for the Medicaid populations for which they are responsible.

Concerning the Medicaid program, the Senate bill has several components:

1. Alison Acosta Fraser, Other Authors, and Stuart Butler, "Taking Back our Fiscal Future," The Brookings Institution and The Heritage Foundation, April 2008, http://www.heritage.org/budget-and-spending/report/taking-back-our-fiscal-future?_ga=2.148092850.429734865.1499699268-2099119272.1499087670 (accessed July 10, 2017).
2. Doug Badger, "The Medicaid FMAP Under the ACA: Disparate Treatment of Eligible Populations Warrants Scrutiny," George Mason University, Mercatus Center, *Mercatus Working Paper*, 2017, p. 3, https://www.mercatus.org/system/files/mercatus-badger-medicaid-fmap-aca-v1.pdf (accessed July 10, 2017).
3. Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027*, June 2017, p. 14, Table 2, https://www.cbo.gov/publication/52801 (accessed July 10, 2017).
4. Congressional Budget Office, *H.R. 1628, Better Care Reconciliation Act of 2017*, Cost Estimate, June 26, 2017, p. 33, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf (accessed July 10, 2017). Cited hereafter as CBO BCRA Cost Estimate.
5. See Virgil Dickson, "CMS Offers Solutions as Improper Medicaid Payments Skyrocket," Modern Healthcare, August 30, 2016, http://www.modernhealthcare.com/article/20160830/NEWS/160839990 (accessed July 10, 2017).

Per Capita Payment. The bill would allocate federal monies to the state Medicaid programs on a per capita basis for the different covered Medicaid populations they serve.[6]

Per capita funding for the state would be determined by the average spending for the category of enrollees and the number of enrollees in the state.[7] States would select eight quarters of Medicaid spending between 2014 and 2018 to set the base for their per capita allotments.[8] Per capita payment would increase annually for each population cohort by indices of inflation.[9] Assuming enactment in 2017, the bill would index per capita payments by medical inflation (CPI-M), which rises much faster than general inflation. Over the 2020–2024 period, the index would be medical inflation plus 1 percent (CPI-M+1) for the aged and disabled, while a simple medical inflation index would apply to per capita payment increases for children, adults, and those who are "newly eligible" for Medicaid coverage under the Obamacare expansion. Beginning in 2025, per capita spending for all categories would be indexed to the conventional measure of general inflation (CPI-U).

To secure equity in the payment system based on "mean" per capita expenditures, the Secretary of the Department of Health and Human Services (HHS) could reward states for savings or reduce state payments for excessive spending from 0.5 percent to 2 percent in any given year. The Secretary could also reduce a state's payments by 1 percent if the state fails to report the necessary data on its Medicaid spending and enrollment.[10]

Block Grant. The Senate bill would provide an alternative method of federal Medicaid payment: a block grant, called the Medicaid Flexibility Program. It would be effective in fiscal year (FY) 2020. Federal payment would be based on a state's Medicaid spending and number of enrollees and would be adjusted for population growth and inflation (CPI-U).

The Senate bill specifies what Medicaid benefits states must cover under the block grant, but it would also allow the states to add benefits at their own expense. The bill would give states broad flexibility in administering the program, subject to federal reporting requirements with respect to data and performance. For example, state officials could run the Medicaid program more as private insurance is run and could determine premiums, deductibles, and cost sharing for enrollees. Under the Senate bill, however, a family's health costs could increase only up to 5 percent of its income. The Senate bill also provides for bonus payments for states whose performance in providing quality medical care meets widely accepted quality standards.

Payment Equalization. States that expanded Medicaid under the terms and conditions of Obamacare secured much larger shares of federal Medicaid funding than states that did not; in FY 2015, for example, expansion states received 70.36 percent of all federal Medicaid reimbursement.[11]

The Senate bill begins a process of equalizing payment between the 31 Medicaid "expansion states" and the rest of the states. This allows for gradual equalization of federal payments to the states for the newly eligible Medicaid population (childless adults able to work who were enrolled under Obamacare) and the poor and vulnerable populations that Medicaid has traditionally served.

Specifically, the bill phases down the federal payment for the expansion states, reducing payment by 5 percent per year and returning federal payment to the normal federal match rate with all other states after 2023.[12] The states may continue to maintain the eligibility of persons who gained

6. The populations are the elderly, the disabled, and the abled-bodied Medicaid populations, including newly eligible Medicaid enrollees made eligible for Medicaid services under Obamacare.
7. Certain blind and disabled persons, or persons who are Medicare "dual eligible" enrollees, meaning that their Medicare costs are borne by Medicaid, would not be subject to the per capita cap funding formula. Additionally, disabled children would not be funded under the per capita cap calculations, but instead would be financed as they are today.
8. Better Care Reconciliation Act of 2017, Section 130.
9. Better Care Reconciliation Act of 2017, Section 133.
10. Better Care Reconciliation Act of 2017, Section 130.
11. Badger, "The Medicaid FMAP Under the ACA," p. 2.
12. Better Care Reconciliation Act of 2017, Section 126.

coverage under the Obamacare expansion, but at their own expense.[13] At the same time, the Senate bill would increase disproportionate share payments (payments for uncompensated hospital care for the uninsured) for the non-expansion states by an estimated $19 billion over the next 10 years.[14] The bill would also provide an estimated $10 billion in special safety net funding for non–expansion states[15] but specifies that payments to Medicaid providers should not exceed the providers' costs in furnishing health care services.

In order to maintain program integrity, the bill would allow states to make eligibility redeterminations every six months. It also give states the option of imposing work requirements on able-bodied Medicaid recipients.[16]

Fast-Track Waivers. The Senate bill speeds the approval of certain Medicaid waivers. For example, any state with a "grandfathered" managed care waiver can continue that waiver as long as it is "budget neutral." Moreover, if a state wished to apply for a modified managed care waiver, that waiver would be "deemed approved" unless the HHS Secretary—"not later than 90 days"—denies or requests more information concerning the waiver.[17] Likewise, the Senate bill encourages a fast-track approval of home and community-based waivers if a state determines that a waiver would "improve patient access to services." For many senior and disabled persons, home and community-based care, allowing these beneficiaries to remain at home, is a more desirable alternative to securing such services than is institutionalization in a nursing facility.[18]

The Senate bill also encourages stronger cooperation and coordination between state and federal officials in the administration of Medicaid by requiring the HHS Secretary to establish a "process" for soliciting advice from state officials in the administration of state Medicaid plans.[19]

How the Senate Bill Accomplishes Its Medicaid Policy Objectives

Critics of the Senate bill focus largely on the impact of federal Medicaid payment changes on access and enrollment. As drafted, however, the Senate bill is a good start at addressing problems in current law while also protecting the most vulnerable.

Controlling the Rate of Growth in Medicaid Spending. The Senate bill's per capita cap formula would have little near-term effect on federal Medicaid spending, since the major budgetary effect would come from changes in Medicaid enrollment. Over time, however, with accumulation of year-to-year savings, its long-term fiscal impact would benefit federal taxpayers. After 2025, the proposed new payment system, indexed to general inflation, would slow the growth of Medicaid more quickly.

Per capita caps do not cut the program or anyone from the program; rather, they limit the rate of spending growth In other words, the federal government will be paying progressively higher amounts to the states over the next 10 years and beyond, but at a slower rate than it would under an open-ended entitlement.

Democrats and Republicans alike have opted for slowing per capita spending growth as a way to control rapidly rising entitlement costs, the major drivers of federal deficits and debt. For example, in enacting the ACA, the Obama Administration and its allies in Congress for the first time in the history of the program imposed a hard cap on Medicare spending,

13. "States would be free after 2024 to continue coverage for the expanded population to plan if and how they want to continue expanded eligibility. It will also give them time to expand private insurance markets to those at or below the poverty line, since the BCRA removes the lower income limit on premium tax credits to purchase insurance. Adults displaced by the phase-out of the Medicaid expansion and residents of the states that did not expand Medicaid could use these credits to purchase private insurance." Joel Zinberg, "The Republican Health Plan: Good, Bad, and Ugly," *City Journal*, June 29, 2017, https://www.city-journal.org/html/republican-health-plan-good-bad-and-ugly-15299.html (accessed July 10, 2017).
14. Better Care Reconciliation Act of 2017, Section 127; CBO BCRA Cost Estimate, p. 34.
15. CBO BCRA Cost Estimate, p. 34.
16. Better Care Reconciliation Act of 2017, Section 131.
17. Better Care Reconciliation Act of 2017, Section 136.
18. Better Care Reconciliation Act of 2017, Section 136.
19. Better Care Reconciliation Act of 2017, Section 137.

indexed (effective in 2018) to the growth of the general economy (measured by GDP) plus 1 percent.[20]

Targeting Assistance to Those Most in Need. Obamacare expanded Medicaid coverage beyond the traditional Medicaid populations to a new population of adults and provided federal funding at 90 percent of the total costs (after 2020) for this population.

The key policy question is whether federal taxpayers should finance newly eligible Medicaid enrollees, mostly able-bodied adults, at levels much higher than they finance the poorest and most vulnerable members of society: the disabled, elderly, pregnant women, and children in poverty.

The right answer is no. The Senate bill properly sets Medicaid's fiscal and policy priorities and would equalize the federal payments between poor elderly and children and "newly eligible" childless adults. This would reverse Obamacare's policy of providing dramatically higher federal payments to states (initially 100 percent of the costs versus 50 percent–75 percent for the original populations) for adding able-bodied adults, many of whom are employed or capable of employment. "Every policy choice has winners and losers," as Mercatus Center Senior Fellow and former Medicare Trustee Charles Blahous, reminds us. "We could continue elevated federal support for Medicaid expansion, which would favor state taxpayers and childless adults over federal taxpayers and poor children, seniors, people with disabilities and pregnant women. Or we could end it, which would have the opposite effect."[21]

Meanwhile, the per capita cap payment system would not change the requirement to serve the mandatory populations under Medicaid—the disabled, elderly, children, and pregnant women in poverty—in any way. Over the 2017–2024 period, Medicaid spending for the elderly and disabled, the two largest cohorts of Medicaid beneficiaries, would grow at medical inflation plus 1 percent, which is higher than the rate of growth for these populations under current law. The CBO reports that the per capita cap approach will have only a "small effect" on spending for these populations.[22]

At the same time, the Senate bill expands the health insurance premium tax credit down the income scale to persons below 100 percent of the FPL and extends this relief to those who are not eligible for Medicaid. This will enable able-bodied individuals to buy private insurance rather than diverting resources from Medicaid. While these new tax credit recipients might be able to purchase health insurance, they might have trouble coping with higher out-of-pocket expenses. State officials will have greater flexibility to address their needs and could, for example, tap into the federally funded State Stability and Innovation Fund to offset those costs among low-income persons, including those previously enrolled in Medicaid.

Allowing States Greater Flexibility. The proposed Medicaid reforms will result in transitions for those who are affected by the Obamacare expansion. Recognizing this, the Senate bill provides $50 billion in funding over the period from 2018 to 2021 "to fund arrangements with health insurance issuers, to address coverage and access disruption and respond to the urgent health care needs within the states."[23]

The bill also creates a Long-Term State Stability and Innovation Program with a total of $62 billion in federal funding for the states.[24] This special program would provide states with funds for high-risk pools; reduce premium costs for high-risk persons, persons who are heavy utilizers of medical services, and persons without employer coverage; and help persons in the individual market secure affordable coverage, including offsetting their out-of-pocket medical costs. The states pick up a progressively larger share of the costs, up to 35 percent by 2026.[25]

20. Under Obamacare, the Independent Payment Advisory Board (IPAB) is to enforce the cap by recommending Medicare payment cuts to meet the annual spending targets based on GDP growth. For a discussion of this provision, see Robert E. Moffit, "Obamacare and the Independent Payment Advisory Board: Falling Short of Real Medicare reform," Heritage Foundation *WebMemo* No. 3102, January 19, 2011, http://thf_media.s3.amazonaws.com/2011/pdf/wm3102.pdf.
21. Charles Blahous, "Why the Fear Mongering on Medicaid Is Totally Overblown," *The Washington Post*, June 28, 2017, https://www.washingtonpost.com/opinions/why-the-fear-mongering-on-medicaid-is-totally-overblown/2017/06/28/46dd74fc-5b7b-11e7-9b7d-14576dc0f39d_story.html?utm_term=.0dbf2ff16d43 (accessed July 10, 2017).
22. CBO BCRA Cost Estimate, p. 29.
23. Better Care Reconciliation Act of 2017, Section 106.
24. CBO BCRA Cost Estimate, p. 23.
25. Better Care Reconciliation Act of 2017, Section 106.

The Senate bill does not disenroll anyone, including able-bodied Medicaid recipients, from coverage, nor would it determine that anyone "loses" their insurance coverage. Nonetheless, the CBO projects, over 10 years, an estimated 15 million fewer persons in Medicaid and says that "[s]ome of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would, under current law, *become eligible in the future as additional states adopted the ACA's option to expand eligibility.*"[26] Not only does CBO concede that its estimates are highly uncertain,[27] but it is projecting a reduction of future hypothetical Medicaid beneficiaries—recipients who do not literally exist—premised on the assumption that states would continue to expand that able-bodied population despite the bill's progressive reduction of federal payments for the Medicaid expansion.

Congress should question the CBO's assessment of the individual mandate. In 2018, for example, the CBO expects that there will be 4 million fewer persons with Medicaid coverage (of 15 million total newly uninsured) "*primarily because the penalty for not having insurance would be eliminated.*"[28] Remarkably, the CBO is saying that eligible persons will not enroll in a welfare program to get "free" care—no premiums and minimal out-of-pocket costs—unless they are forced by law to do so and threatened with a tax penalty if they do not.[29]

In any case, over the next 10 years, as Blahous observes, Medicaid enrollment is projected to hold "roughly constant" above 70 million enrollees, which is much higher than the 55 million enrolled in the program before the enactment of Obamacare in 2010.[30] This enrollment would be maintained despite the fact that the Senate bill would reduce federal Medicaid payments by $772 billion over 10 years.[31]

Conclusion

The Senate health bill addresses a central health policy issue: the structure, function, and financing of the Medicaid program, which in terms of enrollment is the nation's largest health program. This would secure a significant federal entitlement reform.

The Senate bill would achieve three major policy goals: Control Medicaid costs by replacing automatic federal spending increases with a more rational and predictable system of Medicaid funding; target Medicaid funding to the poorest and most vulnerable members of society while cutting back federal payments to childless adults who are able to work; and provide greater flexibility to state officials to manage their own Medicaid programs.

*—**Robert E. Moffit, PhD,** is a Senior Fellow in the Center for Health Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

26. CBO BCRA Cost Estimate, p. 16 (emphasis added).
27. "Such estimates are inherently inexact because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals and other affected parties would respond to the changes made by this legislation are all difficult to predict." Ibid., p. 9.
28. Ibid., p. 4 (emphasis added); see also Doug Badger, "Free the Obamacare 15 Million," *National Review Online*, June 26, 2017, http://www.nationalreview.com/article/448991/senate-health-care-bill-will-reduce-coverage-15-million-good (accessed July 10, 2017).
29. "If CBO is right, these 15 million Americans would take immediate advantage of a provision freeing them from the obligation to obtain a product they neither want nor feel they need." Badger, "Free the Obamacare 15 Million."
30. Blahous, "Why the Fear Mongering on Medicaid Is Totally Overblown."
31. CBO BCRA Cost Estimate, p. 5.