kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

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# MEDICAID AND THE BUDGET CONTROL ACT: WHAT OPTIONS WILL BE CONSIDERED?

## OVERVIEW

On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law. The Act, passed as the nation was about to breach the debt ceiling, was designed to reduce federal spending and raise the debt ceiling. The Budget Control Act established the Joint Select Committee, also known as the "Super Committee," which will be tasked with decreasing projected deficits by $1.5 trillion between FY2012 and FY2021. The Committee has broad authority to propose changes to meet its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. If the Joint Select Committee fails to enact a proposal by January 15, 2012 or the proposal saves less than $1.2 trillion, an automatic reduction in federal spending of $1.2 trillion less the amount saved by the Joint Select Committee would occur through a sequestration beginning in January 2013. Social Security, Medicaid, and other programs serving low-income individuals would be exempt from the sequestration.

As the Super Committee begins its work, the Administration released the President's Plan for Economic Growth and Deficit Reduction on September 19, 2011.[i] The Administration proposal assumes $3 trillion in deficit reduction proposals over the next decade – enough to pay for the Administration's recently released American Jobs Act and hit the deficit reduction targets in the Budget Control Act. The plan includes revenue increases and spending reductions, including cuts to Medicaid. The Super Committee may consider this plan, as well as plans from other deficit reduction commissions. This brief provides a summary of some of the Medicaid proposals (including those recently proposed by the President) that could be considered by the Super Committee in an effort to achieve deficit reduction targets.

## BACKGROUND

Medicaid covers about 60 million low-income Americans. The program provides health coverage for low-income families who lack access to other affordable coverage options, for individuals with disabilities for whom private coverage is often not available or adequate and for seniors who need long-term care services and supports or assistance in affording their Medicare coverage. Total spending for Medicaid was about $387 billion in 2009[ii], with the federal government paying about 57 percent and the states paying the remaining 43 percent. While children and their parents account for 75 percent of all enrollees, the elderly and disabled account for two-thirds of total spending on the program.

Medicaid is a counter-cyclical program, meaning that demand increases during economic downturns. Under the entitlement structure of the program, individuals who become eligible are guaranteed coverage and states are guaranteed federal matching payments; this structure helps to meet changing needs for the program. From the start of the recent recession in December 2007 through June 2010, Medicaid enrollment has increased by more than 7 million as millions of individuals lost jobs and incomes declined. Driven by the recession and the continued weakened economy, recent census data shows that the poverty rate in 2010 reached a near record high with 46.2 million Americans living in poverty.

Over the next decade, the Congressional Budget Office estimates that federal Medicaid spending will reach $554 billion by 2021. Increases in federal spending account for the Medicaid expansion under the ACA, increases in health spending, the aging of the population, and other changes anticipated under current law. Due to Medicaid's large and growing share of the federal budget, the program has been targeted for potential cost savings. Recent proposals to reduce federal Medicaid spending include the President's Plan for Economic Growth and Deficit Reduction, the Bowles-Simpson Proposal, the Domenici-Rivlin Proposal, and the House Budget Resolution. While not specific to Medicaid, the proposal released by the Gang of Six (a bipartisan group of Senators) would require program integrity savings in entitlement programs and would mandate a review of total federal health care spending starting in 2020 with a target of holding growth to GDP plus one percent per beneficiary; Congress and the President would be required to act if that limit were exceeded.[iii] The proposals vary in terms of the magnitude of Medicaid savings to be achieved and the nature of the proposed reforms. Some proposals would fundamentally alter the structure and financing of the Medicaid program, which could have significant implications for the populations served as well as the states. Other proposals offer more modest changes in terms of savings and scope of the policy changes.

The debate over Medicaid's role in federal deficit reduction discussions goes on as states continue to implement an array of measures to control Medicaid costs in response to recession driven budget shortfalls and enrollment increases. As states continue to restrict provider payment rates, cut or limit benefits, and move forward with payment and delivery system reforms within the current rules of the program reductions in state spending for Medicaid result in lower federal spending due to the shared nature of financing. Focus on Medicaid cuts also follows the enactment of the ACA which included a significant expansion of Medicaid in 2014.

## OVERVIEW OF THE BUDGET CONTROL ACT

The Budget Control Act of 2011 raises the debt ceiling by up to $2.4 trillion. The initial $900 billion increase coincides with a round of spending reductions (caps in discretionary spending and changes to student loan programs). An additional increase in the debt ceiling of $1.2 to $1.5 trillion will be tied to further deficit reduction measures. These measures could be achieved through enactment of legislation put forth by a newly established Joint Select Committee or through automatic reductions in spending through sequestration. These actions will occur in multiple steps in accordance with a timeframe set in the law (Figure 1).

Figure 1

### The Budget Control Act of 2011: Key Dates

| Date | Action/Deadline |
|---|---|
| **2011:** | |
| **Sept. 16** | Joint Select Committee meets |
| **Sept. 21** | Debt ceiling raised by additional $500 billion unless Joint Resolution of Disapproval is enacted |
| **Oct. 1 – Dec. 31** | Congress required to vote on Balanced Budget Amendment |
| **Oct. 14** | Deadline for House and Senate committees to send suggestions to Joint Select Committee |
| **Nov. 23** | Deadline for Joint Select Committee to vote on proposal |
| **Dec. 23** | Deadline for Congress to vote on Joint Select Committee bill |
| **Late 2011/2012 [Exact date to be determined]** | Debt ceiling to increase by $1.2 - $1.5 trillion, unless Joint Resolution of Disapproval is enacted |
| **FY 2013 – FY 2021** | Sequester of $1.2 trillion, less the amount saved by the Joint Select Committee |

SOURCE: Kaiser Family Foundation analysis of Budget Control Act law.

The 12-member Super Committee has broad authority to propose changes to meet its budget target of $1.5 trillion between FY2012 and FY2012, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. The Committee is required to draft and vote on a proposal for decreasing the debt by November 23, 2011. Congress will consider the Committee's proposal under expedited rules with a simple majority vote by December 23—one month after the deadline for the Committee to vote on its proposal. The proposal must be enacted into law by January 15, 2012 to avoid automatic, across-the-board reductions in government spending through sequestration. Social Security, Medicaid, and other programs serving low-income individuals would be exempt from the sequestration. The Budget Control Act also requires Congress to vote on a Balanced Budget Amendment to the Constitution between October 1 and December 31, 2011.[iv]

**MEDICAID DEFICIT REDUCTION PROPOSALS THAT THE SUPER COMMITTEE MAY CONSIDER**

Given the short time that the Super has to develop deficit reduction proposals, it is likely that the Committee will draw on proposals that have already been debated. Medicaid savings proposals were included in the recent deficit reduction proposal released by the President as well as numerous other deficit commission reports. The primary Medicaid proposals that have emerged in these plans are highlighted below.

**Medicaid Proposals in The President's Plan for Economic Growth and Deficit Reduction**

The President's plan includes $320 billion in health savings over the next decade including $66 billion in Medicaid savings.[v] Many of these proposals were included in the President's Framework for Shared Prosperity and Shared Fiscal Responsibility released in April 2011. The following highlights the primary Medicaid proposals in the September 2011 plan and the savings estimated by the Office of Management and Budget:

***Limitations on Medicaid Provider Taxes.*** Under the current Medicaid program states have discretion as to the source of the state share of Medicaid program costs. Current law allows states to use revenue from provider taxes to make up the state share of Medicaid; however, states must follow federal rules in designing their provider tax structures. Almost all states have at least one provider tax in place. The President's proposal would modify federal rules to limit the amount of provider tax revenue that states may use to fund their share of Medicaid program costs. Specifically, the proposal would phase down the Medicaid provider tax threshold from the current law level of 6 percent in 2014, to 4.5 percent in 2015, 4 percent in 2016, and 3.5 percent in 2017 and beyond. This would shift costs to states; because states vary in the extent to which they utilize provider taxes, the effect of the changes could vary significantly across states.[vi] ($26.3 billion in federal savings over 10 years.)

***Blended Match Rate.*** Under current law, a formula that relies on state per capita income determines the federal matching percentage (FMAP) for Medicaid. States receive an enhanced FMAP (eFMAP) for the Children's Health Insurance Program (CHIP) and the ACA provides for full federal financing of newly eligible individuals from 2014 to 2016 and then phases that rate down to 90 percent by 2020. Under the President's plan, these variable FMAP rates would be replaced with a state specific single rate beginning in 2017. Higher enrollment of new eligibles between 2014 and 2016 with 100 percent federal financing

could boost a state's blended rate in 2017. The rate would also increase if a recession forces enrollment and State costs to rise. ($14.9 billion in federal savings over 10 years.)

***Amend modified adjusted gross income (MAGI) to include Social Security benefits.*** Starting in 2014, eligibility for Exchange tax credits and cost sharing reductions, Medicaid, and CHIP will be determined based on an individual's or families' MAGI, as defined under the Affordable Care Act. The President's plan would amend the definition of MAGI to include the total amount of Social Security benefits, rather than just the taxable portion. ($14.6 billion in federal savings over 10 years.)

***Other Proposals.*** Starting in 2013, the President's plan would limit federal reimbursement for Medicaid spending on certain DME services to what Medicare would have paid for the same services in a specific state ($4.2 billion in federal savings over 10 years). The President's plan would tighten third-party liability for Medicaid beneficiary claims. Specifically, the proposal would allow states to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, allow providers to collect medical child support for children with health insurance through a non-custodial parent, and allow Medicaid to recover costs from beneficiary liability settlements ($1.3 billion in federal savings over 10 years). The plan would continue the Disproportionate Share Hospital (DSH) payment reductions already enacted under the ACA that account for increased coverage and reductions in uncompensated care ($4.1 billion in federal savings over 10 years). The President's plan also includes a number of proposals to reduce waste, fraud, and abuse in Medicaid ($110 million in federal savings over the next 10 years).

**Medicaid Proposals in Other Deficit Reduction Proposals**

***Medicaid Block Grants.*** Proposals to convert Medicaid to a block were included in the House Budget Plan as well as the Domenici-Rivlin Plan. The current Medicaid program provides an entitlement to coverage for individuals eligible for the program and also guarantees federal matching payments to states with no cap to meet program needs. A block grant would achieve federal savings by limiting federal spending for Medicaid to pre-set amounts below expected levels. The pre-set levels of funding would not be responsive to program needs. Under a block grant, coverage would not be guaranteed and financing would be guaranteed up to the state's allotment for the year. It would be difficult to equitably allocate limited federal funds across states.[vii] The House Budget Plan would repeal the ACA and transition Medicaid to a block grant with significant reductions in funding relative to current law projections. According to the CBO analysis of the House Budget Plan, large reductions in federal Medicaid payments would probably require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law.[viii]

***Shifting Dual Eligibles into Managed Care.*** The Bowles-Simpson Commission report as well as the Domenici-Rivlin report proposed federal savings by eliminating barriers or mandating enrollment of duals in managed care. Dual eligibles comprise 15% of Medicaid enrollees but 39% of total Medicaid spending. Similarly, they represent 21% of Medicare enrollees but 36% of total Medicare expenditures. The integration of Medicare and Medicaid benefits for dual eligibles can present opportunities for innovation, as part of a broader strategy to improve care for high cost, high need populations. Such

opportunities were recognized in the 2010 health reform law by the creation of the Federal Coordinated Health Care Office, now known as the Medicare-Medicaid Coordination Office, which is charged with improving the integration of Medicare and Medicaid benefits for dual eligibles. The Medicare-Medicaid Coordination Office also is working with the Center for Medicare and Medicaid Innovation (CMMI), which awarded design contracts in April 2011, of up to $1 million each to 15 states to develop service delivery and payment models that integrate care for dual eligibles.[ix] Given some efforts to focus on duals already underway, there is a question about additional federal savings that could be achieved from additional changes.

***Other Options.*** Other options to reduce Medicaid spending would focus on efforts to achieve efficiencies in the program through reform to long-term care financing, continued efforts to balance long-term care delivery across institutional and community-based care, better care management for high-cost enrollees, more efficient purchasing of prescription drugs, and enhanced efforts to ensure program integrity. Some of these options were highlighted in a letter from Secretary Sebelius to all Governors in February 2011 as ways for states to achieve Medicaid cost savings within the current rules of the program.[x] Similar to changes in the delivery of care for dual eligibles, many of these initiatives may not generate savings that would be counted by CBO because these changes could occur without new legislation. The Republican Governors Public Policy Committee released a brief highlighting proposed Medicaid changes that could reduce state and potentially federal costs.[xi]

***Proposed Changes to Medicare Interacting with Medicaid.*** A number of proposals would raise the age of Medicare eligibility above age 65. A recent study examined the effect of increasing the age of Medicare eligibility to age 67, assuming the new avenues to public and private coverage in the ACA would be available to individuals between 65 and 67. The study estimated net reductions in federal spending of $5.7 billion in 2014, accounting for gross federal savings of $31.1 billion, offsets by new costs for federal premium and cost-sharing subsidies under the Exchange ($9.4 billion), expanded coverage under Medicaid ($8.9 billion), and a reduction in Medicare premium receipts ($7.0 billion).[xii] Because Medicaid provides assistance to low-income Medicare beneficiaries in paying for premiums and cost-sharing, policy changes to Medicare in these areas will also have implications for Medicaid.

**LOOKING AHEAD**

There are many challenges that lie ahead. The Budget Control Act requires Congress to agree on policies to achieve significant deficit reduction in extraordinarily tight timeframes amidst intense political gridlock leading up to the next election in 2012. Additionally, some experts suggest that Medicaid stakeholders may be better off if the Super Committee does not agree on a deal or if a partial deal does not include Medicaid and a sequester is triggered since Medicaid is exempt from the across-the-board spending cuts[xiii]

While the outcome is uncertain, federal reductions to Medicaid spending will undoubtedly be debated. The proposals under consideration may include those recently released in the President's deficit reduction plan and proposals in earlier deficit commission reports. In reviewing various proposals it is important to understand that many options to reduce federal spending for Medicaid could mean shifting

costs and risk to states, localities, providers and beneficiaries. Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly, and individuals with disabilities, financing long-term services and supports not covered by Medicare or private insurance, supporting providers, achieving national health care objectives like improving health and managing epidemics, and promoting economic growth in state economies. Medicaid will play an even larger role under health reform by expanding coverage to reduce the number of uninsured. However, Medicaid's current and future roles for low-income, vulnerable, and uninsured Americans stand to be reshaped by some of the proposals being advanced as part of the deficit reduction debate.

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[i] *Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction.* http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf

[ii] John Holahan, Lisa Clemans-Cope, Emily Lawton, and David Rousseau, *Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009,* Kaiser Commission on Medicaid and the Uninsured, February 2011. by http://www.kff.org/medicaid/upload/8152.pdf

[iii] A Bipartisan Plan to Reduce Our Nation's Deficit, http://assets.nationaljournal.com/pdf/071911ConradBudgetExecutiveSummary.pdf

[iv] For a more detailed description of the Budget Control Act see Kaiser Family Foundation, *The Budget Control Act of 2011: Implications for Medicare*. September 2011. http://www.kff.org/medicare/8216.cfm

[v] Office of Management and Budget, *Living Within Our Means and Investing in the Future, The President's Plan for Economic Growth and Deficit Reduction.* September 2011.

[vi] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing Issues: Provider Taxes,* May 2011. http://www.kff.org/medicaid/8193.cfm

[vii] Kaiser Commission on Medicaid and the Uninsured, *Comparison of Medicaid Provisions in Deficit Reduction Proposals,* updated April 2011. http://www.kff.org/medicaid/8129.cfm *Implications of a Federal Block Grant for Medicaid,* April 2011. http://www.kff.org/medicaid/8173.cfm *House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing,* May 2011. http://www.kff.org/medicaid/8185.cfm

[viii] Letter to Honorable Paul Ryan, *Long-Term Analysis of a Budget Proposal by Chairman Ryan,* Congressional Budget Office, April 5, 2011.

[ix] Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS,* August 2011. http://www.kff.org/medicaid/8215.cfm

[x] Letter from Secretary Sebeluis to Governors, February 3, 2011, http://www.hhs.gov/news/press/2011pres/01/20110203c.html

[xi] Republican Governors Public Policy Committee, *A New Medicaid: A Flexible, Innovative and Accountable Future,* August 30, 2011.

[xii] Kaiser Family Foundation, *Raising the Age of Medicare Eligibiliyt: A Fresh Look Following Implementation of Health Reform,* July 2011. http://www.kff.org/medicare/upload/8169.pdf

[xiii] Christopher Jennings, *Fallback Cuts or Super-Committee Concoction – Choosing Health Care's Policy Position,* NEJM, 10.1056.

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.