The Economics of Medicaid Reform and Block Grants

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By Paula Chatterjee, MD, MPH, and Benjamin D. Sommers, MD, PhD

Since its passage in 1965, Medicaid has expanded and contracted with the political tides. With concurrent Republican executive and legislative control in 2017, conservative policy makers have already declared their desire to repeal the Affordable Care Act (ACA) and its Medicaid expansion, which has been responsible for approximately 12 million of the 20 million individuals who became newly insured as a result of the ACA. But proposals for fundamental reform of Medicaid are even more far-reaching in terms of their consequences for the other 60 million low-income children, parents, the elderly, and individuals with disabilities who rely on the program. Understanding the rationale for and likely effects of these proposals is critical for physicians and patients alike.

Arguments for Medicaid Reform

Republican leaders have outlined a number of concerns with the current state of Medicaid, including fraud and waste, access barriers due to clinicians’ and health care organizations’ refusal of Medicaid patients, poor health outcomes, and intrusive federal regulations. Some of these concerns are supported by research, including lower clinician participation rates in Medicaid than in private insurance. However, rhetoric that Medicaid does not benefit its enrollees is contradicted by evidence demonstrating that expanding Medicaid leads to increased financial protection, better access to primary care and medications, more preventive care, regular care for chronic disease, improved self-reported health, and lower mortality.

Other arguments focus on Medicaid’s financing structure. Medicaid is funded by the Federal Medical Assistance Percentage (FMAP), under which the federal government pays for a fixed share of all eligible Medicaid spending, ranging from 50% for higher-income states up to about 74% for lower-income states. Under the ACA, the terms of this system became even more favorable to states, with 100% of costs for newly eligible adults paid for by federal dollars (declining to 90% by 2020). However, states must still contend with high health care costs for those enrolled in Medicaid who were eligible prior to the ACA, which may hamper their ability to invest in other priorities. Some critics also argue that under this system, states lack an adequate incentive to reduce spending on their own.
Republican Proposals

House Speaker Paul Ryan (R, Wisconsin) presented a Republican vision for Medicaid reform in June 2016, which offers states the choice between 2 options for fundamental reform. One option, a block grant, replaces the FMAP system with an annual lump sum for each state to spend within broad federal guidelines that are yet to be determined. Under this approach, if a state Medicaid program spends beyond its federal block grant for the year, those expenses become the responsibility of the state.

The second option is a per capita allotment. Instead of a lump sum, states would receive a fixed amount of federal funding for each enrollee in Medicaid, partially insulating states against unexpected increases in enrollment due to recessions and other factors. But once that federal allotment is spent, states would pay the full cost of any additional services per enrollee.

Policy Implications

The most important implication of these proposed reforms is a major reduction in federal funding for the Medicaid program, depending on the specifics of funding. Based on related legislation in the 2016 House Republican budget proposal, the proposed reforms are estimated to result in a $180 billion per year reduction in federal Medicaid spending over the coming decade. For context, federal spending on Medicaid in 2016 was $345 billion.

How would the proposed reforms achieve such dramatic reductions? For any block grant, the critical questions lie in how initial allotments are determined and how those allotments change over time. On the first point, the Ryan block grant option eliminates funding for the ACA’s Medicaid expansion, which primarily covers parents and childless adults with incomes below 138% of the federal poverty level. Although the per capita allotment option grandfathers in states that expanded Medicaid by January 2016, it gradually ratchets down federal funding for expansion from the current 100% level to the pre-ACA match rate.

Perhaps even more important, the Ryan plan proposes indexing changes in federal Medicaid grants over time to general inflation. Historically, medical cost growth far outstrips general inflation. If Medicaid growth is linked to inflation, states potentially face billions of dollars in shortfalls each year that will worsen over time.

Under these pressures, states will face difficult choices. States can raise taxes substantially. They can reduce spending on education and transportation. They can cut Medicaid spending by limiting covered benefits, reducing enrollment, or lowering payments to clinicians and hospitals. While some argue that states would be forced to improve the efficiency of the program, even successful delivery redesign efforts in the United States have produced only modest savings, nowhere near as large as needed to cover the decreasing federal funds.

Moreover, the underlying economics of block grants or per capita allotments suggest that states will reduce spending well before federal shortfalls ensue. States currently receive federal funding for Medicaid only if they contribute their own share. A state receiving a 60% match rate has to put in 40% to obtain any federal funds. The Ryan plan eliminates this requirement, so a state that currently spends $8 billion a year of its own funds on Medicaid in order to obtain $12 billion in federal funds would have the option of collecting $12 billion in federal funds while spending less of its own money—in theory, even $0. Although some states may try to maintain their Medicaid programs as is, others—particularly those with fewer resources or more conservative leadership—will almost certainly spend less.
Increased state flexibility could also lead to other changes in Medicaid. More cost-sharing is likely, and several states have discussed employment requirements for coverage and incentives for healthy behaviors. Some of these might promote a more efficient program or better health; others might leave beneficiaries with inadequate coverage.

Payment policies might also change. If the current enhanced support for federally qualified health centers through Medicaid’s “cost-based reimbursement system” is eliminated, health centers would have difficulty providing services that are critical to their patient populations, such as case management, community health workers, and interpreter services. Although some have argued that low physician reimbursement is a justification for reform, states already have wide discretion in setting physician payment rates in Medicaid. There is thus little reason to suspect that these proposals will lead to higher payment rates, especially when federal funding to states will be markedly reduced over time.

Fundamental Medicaid reforms will have broader-reaching consequences, particularly for the most vulnerable patients in our health care system. How physicians and patients engage with this debate remains to be seen, but the stakes could not be higher.

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