PUBLICATION

Medicaid: Significant Changes Coming in 2017 and Beyond

Authors: Sheila P. Burke
January 09, 2017

With Congress back in session, attention in the health care policy universe is directed squarely at Washington, where Republicans in Congress and the Trump Administration are debating how to repeal and replace the Affordable Care Act (ACA). In addition to this, Republican congressional leadership has renewed its call to fundamentally alter Medicare and Medicaid.

Of particular focus will be Medicaid, the government-run health care program for low-income Americans. The program, which is a shared federal/state program which cost the federal government $334 billion in fiscal year 2015, is a frequent target of congressional Republicans who aim to slow the escalating costs and provide states with more flexibility to implement the program. The two primary initiatives aimed at Medicaid are the ongoing push to transform Medicaid into either a block grant or per capita grant program and the effort aimed at repealing and replacing the ACA and the constituent Medicaid expansion. Each of these, if successful, will have a significant and potentially transformative effect on the Medicaid program.

Medicaid Block Grant and Per Capita Cap Proposals

Since winning unified control of the federal government in November, congressional Republicans have renewed their effort to transform Medicaid from a joint federal/state matching program to either a block grant or per capita cap program. The goals of the proposed changes are to provide greater predictability of spending, enable the federal government to lessen its financial obligations under Medicaid and to allow states to have more flexibility to implement the program. This would be achieved by determining a baseline financing amount for each state or beneficiary group in a state and then selecting a specified fixed growth rate for federal spending thereafter that is less than the anticipated cost increases.

Under a block grant program, in lieu of Medicaid's open-ended matching structure, the federal government would set an amount of spending for each state based on aggregate, historical spending levels and then would allow it to grow at a predetermined rate (Speaker Paul Ryan's (R-WI) *Better Way* proposal gives states the option of either shifting to a block grant or a per capita cap). Under the per capita plan, payments are set to a fixed amount per enrollee instead of the aggregate, as is the case with block grants. This amount is then increased annually by a predetermined rate, similar to a block grant. The per capita cap can be more responsive to varying levels of Medicaid enrollment than a block grant – which remains static except for annual increases – as total spending under a capita cap increases and decreases with enrollment numbers from year to year. However, a per capita proposal can take two forms, one in which each Medicaid recipient in a state is set to a single state-wide payment level, or one in which payment levels are set for each recipient within a given enrollment group, such as the aged. Whether policymakers elect to move forward with an "across the board" per capita cap or an enrollment group-specific per capita cap will have a significant impact on total Medicaid payment levels.

There are both benefits and challenges to transitioning to this kind of model. Benefits include increased budget predictability (for both states and the federal government), lower costs to the federal government (assuming the growth rate is set lower than the current expected growth rate) and increased flexibility for states to implement Medicaid in a way that meets needs of their particular state. The drawbacks to preset growth rates are they do not account for changes in the costs of medical services, patient acuity or epidemics. A policy

change along these lines would also lock in current dramatic variations in the federal Medicaid dollars sent to each state. It is estimated that spending per Medicaid enrollee varies by a factor of about 5 to 1 across the states. Lastly, Medicaid financing reform is often tied to changes in core requirements, which would give states additional flexibility but could result in fewer services, greater limits on coverage and lower reimbursement rates for various services currently covered under Medicaid, such as long term care and prescription drug coverage.

Repeal of the Affordable Care Act

As part of the ACA, Medicaid was expanded from its prior focus on four primary targets – elders and persons with disabilities, children, pregnant women and select parents – to include coverage for all adults and children with incomes up to 138 percent of the federal poverty level (FPL). Initially, it had been expected that all states would be required to participate in the expansion, but in 2012, the Supreme Court struck down the expansion requirement, leaving it up to each state to decide whether or not to participate. As of today, 31 states (and D.C.) have expanded Medicaid, which now provides coverage to nearly 17 million more Americans than it did before the ACA was adopted. Of these, roughly 11 million are adults who became eligible due to the ACA's Medicaid expansion. If the ACA is repealed, it is likely that most of these people will lose access to the Medicaid program and the 31 states (and D.C.) will lose out on roughly $56 billion per year in federal funding.

Each of the plans put forward by congressional Republicans to "repeal and replace" the ACA, including H.R. 3762, a budget reconciliation bill passed by both the House and Senate in 2015, House Speaker Paul Ryan's *Better Way* and HHS Secretary designee Rep. Tom Price's (R-GA) *Empowering Patients First Act*, do away with the Medicaid expansion. The elimination of the expansion may come with some sort of a transition period, allowing current recipients to maintain coverage most likely through the end of 2017 or for the full duration of a "repeal and delay" (possibly two to four years) currently being debated by congressional Republicans.

The ACA repeal adopted by congressional Republicans in early 2016 (a likely model for what will happen during this year's effort) strikes both the eligibility category for low income adults (up to 138 percent of the FPL) and ends federal funding to cover this population. By striking both sections, the measure eliminates the possibility that states would be able to receive funds at the regular Medicaid matching rate for those covered under the program's expansion. It is possible that some states will be able to continue to cover the expansion population through Medicaid Section 1115 waivers, but any waivers must be budget neutral to the federal government, meaning that any cost included in the program must be covered by cutting spending elsewhere, most likely through reduced benefits or increased cost sharing for the non-expansion Medicaid population.

Other Potential Changes

- **Section 1115 Waivers** – These are federally-issued waivers that allow states to test and implement Medicaid demonstration programs as long as they meet the goals of the Medicaid program and are revenue neutral for the federal government. The incoming Trump Administration may encourage states to submit new or updated waiver applications. It is worth noting that as governor of Indiana, Vice President-elect Mike Pence expanded Medicaid through the use of a Section 1115 waiver designed by CMS administrator designee Seema Verma. The plan, known as *Healthy Indiana 2.0*, includes provisions to impose premiums on most Medicaid beneficiaries; a coverage lock-out period for individuals with incomes above the poverty level who fail to pay premiums; health savings accounts; and health behavior incentives.
- **Children's Health Insurance Plan** – The State Children's Health Insurance Plan (CHIP) provides insurance to roughly 8.1 million children ever year. Congressional funding and authorization for the CHIP program will expire on September 30, 2017, meaning the future of the CHIP program may become entangled with the broader debate over the ACA and Medicaid.

Takeaway

With unified Republican control of the federal government for the first time since 2006, Medicaid and other entitlement programs are likely to be the target of reform efforts aimed at lowering long term costs to the federal government and providing additional flexibility to states. This broader policy agenda combined with the Republican push to repeal and replace the Affordable Care Act means significant changes for the Medicaid program are in the offing and are likely to include both a repeal of coverage for able-bodied adults making less than 138 percent of the federal poverty level and a potential transition away from a federal/state matching partnership to a state block grant or per capita cap system.