Center for American Progress

The Republicans' Plan for Medicaid: A Wolf in Sheep's Clothing

By Maura Calsyn and Thomas Huelskoetter January 12, 2017

President-elect Donald Trump and Republicans in the U.S. Congress are poised to dismantle the Medicaid program, which provides millions of Americans with a health care safety net. First, they plan to repeal key parts of the Affordable Care Act, or ACA—including the law's Medicaid expansion—through the budget reconciliation process without yet offering any replacement plan. Second, congressional plans to drastically restructure the Medicaid program will make coverage less secure for those who remain enrolled in the program.

Republican candidates throughout the 2016 campaign promised to repeal the Affordable Care Act.[1] But their campaign rhetoric focused on the law's individual mandate and the cost of premiums for plans sold in the law's new marketplaces—not on the law's Medicaid expansion. Their diversion was intentional: This part of the law is very popular in states that expanded their Medicaid programs, including states led by Republican governors.[2]

Since the election, coverage of the upcoming repeal vote continues to focus more on the private insurance market than on what a repeal will mean for those who have coverage because of Medicaid expansion. In fact, some news reports have mistakenly suggested that under the Trump administration, more states might expand Medicaid coverage because they will have greater flexibility in designing their Medicaid programs.[3] This assessment is false. Claims by congressional Republicans and President-elect Trump that they plan to give states more control over their Medicaid programs are just a smoke screen. Ideological opposition to safety-net programs such as Medicaid remains their lodestar, and their plans for altering the program will simply reduce federal spending at the expense of low-income Americans.

Congress will eliminate the ACA's Medicaid expansion

The Affordable Care Act has expanded health care coverage to 20 million Americans.[4] A huge part of this success has been the ACA's expansion of Medicaid coverage to all adults with incomes of up to 138 percent of the federal poverty level. In the 31 states and Washington, D.C., that chose to expand Medicaid, almost 11 million newly eligible people have enrolled in coverage.[5] The federal government pays for almost all of the costs of covering these newly eligible 11 million Medicaid enrollees: Through 2016, the federal government has paid for all of these enrollees' costs; starting in 2017, the federal payments will gradually transition to making up 90 percent of funding by 2020 and in future years. Repealing the ACA would eliminate the enhanced federal support that made it possible for states to expand their Medicaid programs to cover these people. A recent analysis by the nonpartisan Urban Institute concluded that if the reconciliation repeal vote succeeds, the states that expanded Medicaid would collectively receive $715 billion less in federal funding for Medicaid and the Children's Health Insurance Program over a 10-year period starting in 2019.[6] As a result, millions of Americans would fall back into the ranks of the uninsured.[7]

The impact of repealing this part of the Affordable Care Act will ripple beyond the millions of Americans who will lose their health insurance. The additional federal funding under Medicaid expansion also helps to bolster state economies. In addition to the direct benefits this funding provides to the newly eligible individuals, as well as the health care providers who care for them, this funding can encourage economic growth as it flows through state economies. For example, if doctors have increased demand for medical supplies because they are treating more patients, there will be also be increased demand by those suppliers for other items and services. These effects can increase government revenue as well; if the flow of Medicaid funds increases household incomes, tax collections will also rise.

For these reasons, a number of Republican-led states chose to expand their Medicaid programs, citing both the health benefits and economic security that Medicaid coverage gives its enrollees, as well as the economic benefits of Medicaid expansion.[8] These Republican governors—including then-Indiana Gov. Mike Pence (R) and New Jersey Gov. Chris Christie (R)—made a commonsense, pragmatic decision to put politics aside and expand their programs.[9] Yet one of the first votes Congress is expected to take in 2017 will eliminate these successful programs. In fact, if the repeal vote in the Senate is tied and Vice President-elect Pence breaks the tie by voting to repeal the ACA, he will be cutting federal support for his own state's Medicaid program by $14 billion over the next 10 years.[10]

Congress will slash Medicaid funding under the guise of state flexibility

The individuals who will remain enrolled in Medicaid if Congress repeals Medicaid expansion are low-income pregnant women, infants, children, parents, seniors, and disabled individuals who were eligible for the program before the Affordable Care Act. Federal block grants have traditionally been the go-to Medicaid proposal from congressional Republicans for cutting federal spending on health care for these vulnerable populations.

Current law guarantees that the federal government will pay a set percentage of all costs incurred by a state's Medicaid program in providing covered services to all eligible individuals. Although the federal share of the costs for individuals who were previously eligible under traditional Medicaid varies between states, it cannot be less than 50 percent; for people eligible under the ACA's Medicaid expansion, the federal government pays almost all of the costs. For traditional Medicaid, the federal government pays a greater share in states with lower average per capita incomes relative to the national average; this year, the federal government will pay from 50 percent to just more than 70 percent of the costs of states' nonexpansion Medicaid programs.[11] And because this is structured as a percentage, state governments know that the federal government will pay that share, regardless of increased enrollment or higher health care costs.

The various block grant proposals would undermine this guarantee and instead give states a set amount of money for their Medicaid programs, while also likely weakening the programs' benefits and eligibility requirements. This would have the practical effect of dramatically cutting federal Medicaid funding over time, because these proposals do not adjust for increased enrollment or higher health care costs in the future. Moreover, the block grant would likely grow yearly based on the general inflation rate, which grows more slowly than health inflation. As a result, these proposals would shift a greater and greater share of the costs of Medicaid to state budgets—forcing states to limit eligibility and benefits or to increase cost sharing by Medicaid enrollees.[12] The Urban Institute has concluded that had past U.S. House of Representatives block grant proposals been enacted, they would have eventually resulted in 14 million to 20 million Medicaid beneficiaries losing coverage by the 10th year.[13] In addition, the block grant would cut payments to doctors and other health care providers by more than 30 percent by the 10th year of the block grant.[14]

Less than a week after Election Day, despite President-elect Trump's campaign pledge not to cut Medicaid, Vice President-elect Mike Pence confirmed the next administration's commitment to gutting the Medicaid program.[15] Speaking at a meeting of Republican governors, Pence said that the Trump administration was committed to replacing traditional Medicaid funding to states with block grants that "encourage innovation that better delivers health care to eligible residents."[16] In another worrying sign for the Medicaid program, he nominated Rep. Tom Price (R-GA)—a long-time

supporter of Medicaid block grants—to be the next U.S. secretary of health and human services.[17] As House Budget Committee Chairman, Rep. Price proposed a budget plan that would turn the program into a block grant and cut $913 billion from the Medicaid program over the next decade.[18] When combined with his proposal to eliminate Medicaid expansion, these cuts total $1.8 trillion over the 10-year period.[19]

The new administration will have the support of Congress if President-elect Trump reneges on his pledge; House Speaker Paul Ryan and congressional Republicans are longtime supporters of block grants. Last summer, House Republicans published a white paper that outlined how they would replace the Affordable Care Act, and not surprisingly, that plan included block grants.[20]

But there is a new twist in how these lawmakers would cut Medicaid funding. They would give states a choice between block grants and per capita caps, which simply limit federal spending at a specific amount per person rather than for the overall state, as block grants do. The House majority will try to spin this proposal as a compromise that is less draconian than block grants, but this is just another way to limit federal funding for Medicaid.

Speaker Ryan's per capita cap proposal includes an immediate cut in Medicaid funding in its first year: The plan would be implemented in 2019, but the amount of the per capita payment would be based on state Medicaid spending in 2016, adjusted only for general inflation. The initial per capita cap level thus would be smaller than actual Medicaid spending in 2019 because health care inflation normally outpaces general inflation. And just like block grants, the per capita caps would also grow more slowly than annual health care inflation, dramatically reducing Medicaid funding over time.[21]

An earlier congressional proposal that used per capita caps to limit federal funds would have cut $1 trillion from Medicaid over 10 years.[22] The Center on Budget and Policy Priorities has determined that all states choosing and implementing a per capita cap "would require cuts to federal Medicaid funding per beneficiary of about 50 percent by the tenth year."[23] As a result of such drastic cuts, many fewer people would be eligible for Medicaid, and those who would remain enrolled would pay higher costs in exchange for reduced benefits.

Regardless of whether Congress ends up choosing block grants or per capita caps, both amount to huge cuts to a crucial part of the health care safety net. And neither sufficiently protects states and Medicaid enrollees if there is an economic downturn or if the prices of health care items and services increase. For example, state Medicaid programs have struggled to find the funds to pay for the new, very effective yet very high priced hepatitis C drugs. Block grants and per capita caps would only exacerbate these difficulties and squeeze state and patient budgets.

Despite the fact that these proposals would massively shift costs onto state budgets, congressional Republicans attempt to frame them as increasing state flexibility. Yet as this cost-shifting demonstrates, these proposals are not designed to improve states' finances, improve health coverage, or limit systemwide costs. Rather, conservatives in Congress have designed them to reduce federal spending, which would undermine this critical safety net program.

The Trump administration can undermine Medicaid even without Congress' help

Even without changing the Medicaid statute, the Trump administration could cause significant disruption to state Medicaid programs and their enrollees. Even the change in the administration may cause significant disruptions, especially because opponents of the health care safety net will be administering those very same programs. Administration officials could stop enforcing requirements they find too burdensome. And the Medicaid statute gives the federal government the ability to approve state-specific changes to the default Medicaid requirements.

Federal law sets general Medicaid requirements, but within those parameters, states have the flexibility to design their own Medicaid programs to meet their state's specific needs.[24] For example, federal law requires states to cover certain mandatory services, such as inpatient hospital services and physician's services. But the Medicaid statute gives states flexibility in setting cost sharing for these services, which may include copayments, coinsurance, and deductibles.[25] There are federal limits on these out of pocket costs, but states can charge more to relatively higher-income people for some categories of services.[26]

States wishing for even greater flexibility to redesign their Medicaid programs may apply for a waiver that will allow them to adopt Medicaid policies that differ from the usual federal Medicaid requirements. As a result, these waivers have a more rigorous, lengthy submission and approval process than the normal flexibility, which is conducted through state plan amendments. States applying for waivers must show that their proposal is cost effective or budget neutral, and the Centers for Medicare and Medicaid Services, or CMS, generally approves waivers for limited periods of time.

There are three categories of Medicaid waivers and demonstrations, each named for the relevant section of the federal Social Security Act. The most expansive waiver authority—and the one that the Trump administration is most likely to use to allow states to impose strict new eligibility and cost-sharing rules—is under section 1115. These demonstration projects are generally statewide and allow states to waive a wide range of federal requirements. In the past, the federal government has approved these waivers in order to allow states to test payment and delivery system reforms to reduce costs and improve quality, as well as to offer a broader set of services to enrollees.

Section 1115 waivers must also be, in "the judgment of the Secretary … likely to assist in promoting the objectives" of the Medicaid program.[27] These objectives include delivering health care services to vulnerable populations who cannot otherwise afford them.

A number of states—include Indiana under then-Gov. Pence—have used section 1115 waivers to design their Medicaid expansion programs to impose more burdensome cost-sharing requirements and premium payments as a requirement for coverage, despite warnings from consumer groups that these types of requirements are inconsistent with the objectives of the Medicaid program. The contents of these waivers provide a preview of the types of conservative state proposals that the Trump administration is likely to approve. In general, these plans seek to make Medicaid function more like an employer-based health care plan, despite the differences between those enrolled in Medicaid and those with access to employer-sponsored insurance.

Under the Indiana waiver, for example, all enrollees must pay premiums in the form of a contribution to a health savings account. The total premium payment may not exceed 2 percent of household income. After payment, the individual is then enrolled in the HIP Plus plan. This is a significant change from standard Medicaid rules, which enroll beneficiaries in coverage once they apply and are determined eligible. In Indiana, if enrollees with incomes between 100 percent and 138 percent of the federal poverty level fail to make these monthly payments, the state drops them from the program, and they may not re-enroll for six months. For enrollees with incomes below the federal poverty level who do not pay their premiums, the state shifts them to the HIP Basic plan, which has more limited benefits.[28]

Although President Barack Obama's administration ultimately approved this structure for Indiana's Medicaid program and has allowed other states to design Medicaid expansion programs that conservative governors tout as encouraging personal responsibility, the administration has pushed back against proposals that took an even more aggressive aim at undermining the objectives of the Medicaid program. For example, the administration required Indiana to reduce the monthly contribution for enrollees with the lowest income levels to $1. In addition, the administration insisted on limits to the six-month lockout period; certain frail and unhealthy individuals are exempt from this requirement, and people whose income is below the federal poverty level may not completely lose their health care coverage. Instead, they will remain eligible for the HIP Basic plan.[29] The Obama administration has also rejected requests to include work requirements in waivers.[30]

But even with these limits, such requirements still succeed in creating barriers to enrollment. Premiums significantly reduce low-income people's enrollment in health care programs.[31] Indiana's Medicaid expansion structure is far more complex, and requires enrollees to jump through many more bureaucratic hoops, than traditional Medicaid rules.[32] It is therefore not surprising that 84 percent of enrollees who the state moved to

HIP Basic plans because they did not pay their monthly premiums said that they found both the program and its premium payment process to be confusing.[33] Enrollment data also show that as of January 2016, the Indiana waiver was covering about 140,000 fewer previously uninsured individuals than the state had originally projected.[34]

The Obama administration chose to approve Indiana's and other similar states' waivers because the alternative was leaving this entire population uninsured. In this way, these early proposals arguably did meet the objectives of the Medicaid program, because they did expand health care services to vulnerable individuals. But many conservative proposals that include even more complex and bureaucratic requirements imitating private insurance are in fact designed to depress enrollment, shift costs to very low-income Americans, and reduce the program's benefits.

A Trump administration will approve many of these troubling proposals, such as work requirements, higher cost sharing, and more flexibility for states to remove enrollees from the program if they do not pay their premiums.[35] In fact, the architect of the Indiana waiver and other similar state proposals is Seema Verma, whom President-elect Trump has nominated to be CMS administrator. Verma's view of Medicaid is fundamentally different from that of Obama administration officials. She claims that redesigning Medicaid in these ways "promot[es] personal responsibility while providing subsidized health protection."[36]

In reality, research shows that the types of policies that conservatives applaud for promoting personal responsibility are really ways to undermine Medicaid's role as a health care safety net. For example, cost sharing and premiums reduce enrollment and access to care because many low-income individuals struggle to afford these payments or find the payment process confusing—not because they are irresponsible.[37] And research also shows that most nonelderly Medicaid beneficiaries already live in a household with either a full-time or part-time worker.[38]

None of this research appears to have persuaded President-elect Trump's nominees for the U.S. Department of Health and Human Services, or HHS, and CMS. Instead, they are likely to double down on these types of proposals to undermine critical safety-net programs such as Medicaid.

Waiver proposals that undermine the Medicaid program

The Trump administration is likely to approve these policies under waivers:

- Requiring enrollees to have even more so-called skin in the game through higher premiums and cost sharing, with greater penalties for nonpayment
- Canceling coverage for enrollees who fail to pay premiums or miss other deadlines and locking them out of re-enrolling for six months
- Establishing work or job-seeking requirements
- Changing standard Medicaid benefits, such as eliminating nonemergency transportation services or vision and dental benefits
- Capping enrollment in the Medicaid program
- Requiring community service or wellness activities to access additional benefits
- Eliminating retroactive coverage for most new enrollees, which they receive under normal Medicaid rules for the three previous months before enrollment

Conclusion

President-elect Trump will enter office armed with a variety of tools to undermine Medicaid's safety-net guarantee, as well as with a Republican Congress eager to pass legislation to roll back the ACA's Medicaid expansion and leave the remaining Medicaid program underfunded. The philosophical belief driving this agenda is that government assistance through programs such as Medicaid—despite its success in providing millions with affordable health coverage—is by definition bad because it discourages some ill-defined, erroneous notion of personal responsibility. Given the intensity of this belief among members of Congress and the president-elect's HHS and CMS nominees, it will be extraordinarily difficult to push back against these actions. But the first critical step is recognizing that the rhetoric of state flexibility and state innovation is really just a cover for an end goal—to gut the Medicaid program.

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