



# Undermining Medicaid

## How Block Grants Would Hurt Beneficiaries

By Tarun Ramesh

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President Donald Trump and his congressional allies have repeatedly tried and failed to repeal the Affordable Care Act (ACA).<sup>1</sup> Various repeal bills have included provisions to slash Medicaid funding by eliminating the ACA's Medicaid expansion and restructuring the remaining program through block grants or per-capita caps.<sup>2</sup> By placing caps on federal Medicaid spending, these programs would either reduce enrollees' benefits or tighten eligibility requirements. Now, after failing to implement these reforms legislatively, the Trump administration is bypassing Congress to cut federal Medicaid expenditures and dismantle key Medicaid expansion provisions of the ACA.

In January, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma was reported to be considering drastic changes to Medicaid's rules that would allow states to adopt structures similar to block grants or per-capita caps using the Medicaid waiver authority—a mechanism to make alterations to Medicaid services without legislative approval.<sup>3</sup> Since then, she has continued to express support for capping federal Medicaid payments to the states.<sup>4</sup>

Block grants and per-capita caps threaten health care access for the almost 75 million low-income and disabled people enrolled in the program.<sup>5</sup> This issue brief outlines the ways in which the administration is encouraging states to use waivers to adopt these alternative funding approaches, thus undermining Medicaid and ignoring the will of voters, who overwhelmingly oppose such programs.<sup>6</sup>

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### Overview of the Medicaid program

Medicaid is funded by both the federal government and states, guaranteeing coverage to all eligible adults and children regardless of total cost. Under this structure, the federal government pays a set percentage of all costs incurred by states in providing services to all eligible Medicaid enrollees. Due to this structure, states know that the federal government will pay its share, regardless of changing economic and social conditions, such as recessions, medical inflation, natural disasters, and population aging.<sup>7</sup> The current flexibility of Medicaid funding is critical to improve patient health outcomes and expand access to quality care without trapping enrollees in cyclical poverty and crushing medical debt.<sup>8</sup>

## Medicaid funding structure before and after the ACA

Prior to the Affordable Care Act, individuals enrolled in Medicaid were almost entirely pregnant women, infants, children, parents, seniors, and disabled individuals who were low income and therefore eligible for the program. For these individuals, the federal share of costs varies between states, but it can never be less than 50 percent.<sup>9</sup> And in states with lower average per-capita incomes relative to the national average, the federal government pays a greater share. This year, the share that the federal government pays will be from 50 percent to slightly more than 76 percent of the costs of states' nonexpansion Medicaid programs.<sup>10</sup>

The Affordable Care Act expanded Medicaid coverage to all adults with incomes of up to 138 percent of the federal poverty level.<sup>11</sup> When states choose to expand their Medicaid programs, the federal government pays for almost all of the costs of covering these newly eligible Medicaid enrollees. Similarly, in the first years of the ACA, the federal government paid for all new enrollees' costs; in 2017, the federal payments began to gradually transition to 90 percent of costs by 2020 and in future years.<sup>12</sup>

Under the ACA, the benefits of Medicaid have become increasingly apparent as health disparities between expansion and opt-out states have widened. Newly eligible beneficiaries are more likely to receive preventive care, attend primary care visits, enroll in an addiction rehabilitation facility, and seek employment.<sup>13</sup> Expanded eligibility also reduced mortality rates by 6 percent in the newly eligible beneficiary population and reduced racial disparities in cancer treatment.<sup>14</sup> On top of these positive health outcomes, Medicaid expansion has generated many economic benefits for beneficiaries and state economies alike, lowering rates of hospital closures, reducing uncompensated costs, growing the domestic health care industry, raising wages in the health care field, and increasing state revenue.<sup>15</sup> Furthermore, states that expanded Medicaid saw an average 13 percent drop in the number of residents with medical debts, demonstrating that the program has helped enhance the standard of living for everyday Americans who might otherwise be saddled with enormous bills.<sup>16</sup>

## Medicaid waivers

Within the general Medicaid requirements set by federal law, states have the flexibility to design their own Medicaid programs.<sup>17</sup> For example, federal law requires states to cover certain mandatory services, such as inpatient hospital services and physicians' services. But states can set cost sharing for these services—including copayments, coinsurance, and deductibles—as long as they do not set these amounts above the federal limit.

States that want to adopt Medicaid policies that differ from the usual federal Medicaid requirements may also apply for a waiver. Waivers have a rigorous, lengthy submission and approval process; states applying for them must show that their proposal is cost effective or budget neutral, and the CMS generally approves waivers for limited periods of time.<sup>18</sup>

The most expansive waiver authority—and the one that the Trump administration has allowed states to use to approve harmful changes to Medicaid—is under Section 1115. Section 1115 waivers are generally statewide and allow states to waive a wide range of federal requirements.<sup>19</sup> In the past, the federal government has approved these waivers in order to allow states to test reforms to reduce costs and improve quality, as well as to offer a broader set of services to enrollees. Under the Obama administration, for example, Section 1115 waivers were used to provide states with extra funding to combat the opioid crisis and expand accessibility to substance use disorder treatment for Medicaid patients.<sup>20</sup> Such waivers were crucial to improving the Medicaid program and reaching vulnerable populations.

Critically, Section 1115 waivers must also be, in “the judgment of the Secretary ... likely to assist in promoting the objectives” of the Medicaid program.<sup>21</sup> These objectives include delivering health care services to vulnerable populations who cannot otherwise afford them. Yet despite this requirement and the importance of the Medicaid program, the Trump administration has approved Section 1115 waivers that are designed to reduce Medicaid spending by cutting eligible individuals from the program, which conflicts with their original purpose.

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## Attempts to undermine Medicaid through block grants and caps

Congressional Republicans have consistently tried to alter the current Medicaid payment structure; two of their long-standing proposals have been to adopt a block grant and a per-capita cap structure.<sup>22</sup> Since President Ronald Reagan’s proposal to block grant the program in 1981, congressional Republicans have consistently put forward similar plans that would limit federal funding and undermine key Medicaid provisions.<sup>23</sup>

A block grant program would cap total federal spending on the program and fix federal funding to a preset formula determined by previous cost estimates that include projected growth and inflation.<sup>24</sup> Per-capita caps would institute a federal spending cap for each beneficiary enrolled in the program.<sup>25</sup> The cap would be estimated from previous costs, but the federal government would only be responsible for funding up to the cap; individual states would have to pay any exceeding costs.

Both the proposed block grant program and per-capita caps undermine funding guarantees, giving states a set amount of money for their Medicaid programs while also likely weakening the programs’ benefits and eligibility requirements.

## Recent legislative efforts to undermine the Medicaid program

Throughout the 2017 effort to repeal the Affordable Care Act, the congressional majority included Medicaid block grant and per-capita cap proposals in various legislative proposals, such as the American Health Care Act, the Better Care Reconciliation Act, the Health Care Freedom Act, and the Graham-Cassidy bill.<sup>26</sup>

According to the Congressional Budget Office, these proposed cuts would require states to take immediate action to either reduce Medicaid expenditures or raise revenue through tax hikes.<sup>27</sup> The former would lead to restrictions on Medicaid eligibility, reductions of provided services, and reduced payments to health care providers. Over time, constant reductions in federal expenditures would force states to bear greater and greater cost burdens until coverage was severely affected. These regressive policies would weaken health care protections for low-income populations in order to reduce federal spending.

### The Trump administration's Medicaid sabotage

While President Trump has thus far failed both to repeal the ACA and to dismantle the structure of Medicaid, his administration continues its efforts to weaken the Medicaid program. In its fiscal year 2020 budget proposal, the Trump administration included block grants as a method for cost-saving measures in the Medicaid program.<sup>28</sup> However, House Democrats issued a statement indicating that a block grant program in the budget was a nonstarter.<sup>29</sup>

Moreover, Centers for Medicare and Medicaid Services Administrator Verma continues to lead the administration's efforts to undermine Medicaid administratively, worsening the quality of care for hundreds of thousands of people in the process. She has approved Section 1115 waivers that include work restrictions, cost-sharing increases, and premium hikes.<sup>30</sup> These waivers would reduce federal health care expenditures by applying eligibility restrictions or increasing cost burdens for vulnerable populations. In essence, by forcing beneficiaries off Medicaid, Verma will be able to cut federal spending for the Medicaid program.<sup>31</sup> House leaders have the constitutional right to assert oversight on members of the administration and therefore should demand that Verma testify on her actions to cut Medicaid.

Meanwhile, the Office of Management and Budget is currently reviewing new guidelines that would allow states to use Section 1115 waivers to implement some type of block grant or per-capita cap structure.<sup>32</sup> While the exact scope of the plan is unknown, Chairman of the House Energy and Commerce Committee Frank Pallone (D-NJ) has already warned Health and Human Services Secretary Alex Azar that Medicaid law specifically prohibits transitioning funding structures to block grants or per-capita caps and that congressional approval would be required for this change.<sup>33</sup>

### *States are following the administration's lead by issuing block grant proposals*

Verma's efforts to weaponize Section 1115 waivers to gut Medicaid are a last-ditch effort by the current administration to fundamentally change Medicaid funding structures.<sup>34</sup> Several conservative states have taken initial steps to be the first state in the nation to have a Medicaid block grant program. This includes the following two states:

- **Alaska's block grant proposal:** Alaska expanded Medicaid in 2015, but according to Alaska Public Media, in a letter to Gov. Mike Dunleavy (R-AK) earlier this year, Verma encouraged Alaskan officials to become "the first state to receive Medicaid dollars as a block grant."<sup>35</sup> In 2018, then-candidate Dunleavy promised to make Medicaid cost effective, hoping to save \$150 million.<sup>36</sup> Now, as governor,

he will have his chance to make sizable cuts to Medicaid. Since Verma's letter, Gov. Dunleavy has written to President Trump indicating his interest in pursuing such legislation in the next session.<sup>37</sup> In June, the state authorized Boston-based Public Consulting Group to develop a proposal for Medicaid block grants.<sup>38</sup> The proposal will likely mirror earlier attempts to gut the state's Medicaid program, which included a \$270 million proposed cut in state Medicaid funding and a corresponding \$480 million reduction in federal expenditures.<sup>39</sup> This would result in the loss of at least 8,000 jobs in a health care industry that has grown significantly in the past few years, even amid a statewide recession.<sup>40</sup>

- **Tennessee's block grant proposal:** In Tennessee, a new law requires the state to submit a Medicaid block grant Section 1115 waiver to the CMS within six months.<sup>41</sup> Unlike Alaska's, Tennessee's has not expanded Medicaid under the Affordable Care Act, so the waiver would only apply to current Medicaid beneficiaries, including low-income children, seniors, and pregnant women.<sup>42</sup> If approved by the CMS, this extreme proposal would reduce services guaranteed to enrollees since the inception of Medicaid in 1965 and set a dangerous precedent that would enable other states to pass similar measures, reversing decades of health care protections.

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## Conclusion

These efforts to implement Medicaid block grants and per-capita caps using Section 1115 waivers would not only critically undermine the federal government's mandate to provide affordable health care for low-income, vulnerable populations, but they would also reduce overall funding for the program and shift Medicaid responsibility to the states. If state Medicaid costs were higher than expected due to increased enrollment as a result of economic shocks or natural disasters, states would be forced to either supplement their Medicaid program from other funding sources, increase taxes, or reduce services provided to enrollees.<sup>43</sup> Alternate Medicaid funding plans do not account for economic volatility or sudden disease outbreaks.<sup>44</sup> In such scenarios, Medicaid enrollment would outstrip projected funding rates, forcing states to bear the extra cost, which in turn would restrict program eligibility or reduce service quality.

Lawmakers have a responsibility to safeguard the Medicaid program from efforts to undermine it through harmful waivers and other administrative actions. For these reasons, it is time for Congress to publicly question Administrator Verma about her actions to bypass Congress.

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