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issue brief

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Federal Budget Plans Would Shift Medicaid Costs to New Hampshire

In fiscal year 2010, as many as 165,000 New Hampshire residents relied on Medicaid, a joint federal-state program that offers long-term care to seniors, provides critical services to help residents with disabilities live independently, and enables children to see a doctor when they are sick or injured. Since its inception in 1965, the program has functioned as a partnership between the two levels of government, guaranteeing not only that anyone eligible for Medicaid receives it, but that federal funds cover a fixed percentage of the actual costs the program incurs.

Yet, a number of recent federal budget proposals would fundamentally recast that partnership. The federal fiscal year 2012 budget resolution adopted by the U.S. House of Representatives, authored by House Budget Committee Chair Paul Ryan (R-WI), would convert Medicaid into a block grant program; that is, in exchange for increased state flexibility in setting eligibility levels and benefit packages, federal funding for Medicaid would be limited to a fixed dollar amount that would grow slowly over time and no longer guarantee coverage for eligible families and individuals. A Senate budget resolution, offered this week by Senator Patrick J. Toomey (R-PA), would also convert Medicaid into a block grant program. Under the provisions of the Ryan Plan, federal funding for Medicaid would decline by $771 billion between 2013 and 2021; under the Toomey proposal, federal funding would drop another $326 billion over the same period – or by more than $1 trillion in total.[i] Both would leave only state dollars available to respond to projected spending growth or to unanticipated increases in enrollment. An alternative proposal, authored by Senators Claire McCaskill (D-MO) and Bob Corker (R-TN), would prohibit federal spending from exceeding a certain percentage of the national economy every year and, as a result, would likely initiate federal funding reductions of $547 billion in Medicaid from 2013 through 2021, with even greater reductions in subsequent years.

To make up for the reductions in federal funding arising from these proposals, New Hampshire either would have to contribute significantly more in General Funds to maintain its current Medicaid program or would have to enact substantial reductions in eligibility and benefits for seniors, poor children, and people with disabilities. For instance, the Kaiser Commission on Medicaid and the Uninsured estimates that, under the Ryan Plan, 47,000 to 68,000 lives would be removed from New Hampshire's Medicaid program by 2021 (depending on how reductions are spread among New Hampshire Medicaid populations) or state spending will have to increase by $800 million per year by 2021 in order to maintain current eligibility and benefit levels.[ii]

Key Aspects of the Current Medicaid Structure

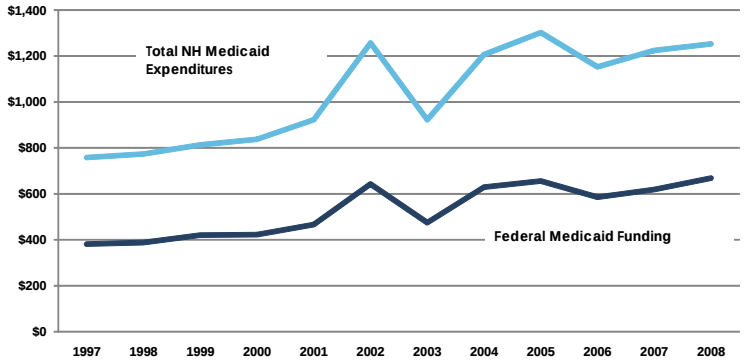
To understand the ramifications of the Ryan and McCaskill-Corker proposals, it is first necessary to understand two key aspects of the current Medicaid structure:

- **Federal funding is provided to states "as needed" and is based on actual costs**.

Currently, federal funding for each state's Medicaid program is a fixed percentage of the costs of the program; in New Hampshire, this percentage is at least 50 percent. Of note, that percentage is of the actual costs of the program, which are dictated by enrollment, utilization, and reimbursement rates. This structure makes federal funding responsive both to changing economic, demographic, and epidemiological circumstances and to the consequences they have for Medicaid expenditures. For instance, as a safety net program, Medicaid is structured to expand during crises, as people lose their jobs, incomes, and/or employer-based health care coverage. In fact, as shown in the figure above, during the economic downturn at the start of the millennium, when New Hampshire Medicaid costs grew by 9 percent in 2000 and 27 percent in 2001, federal financing grew in tandem with those costs.[iii]

Federal Funding for Medicaid Grows with Program Costs Under Current Structure

Total New Hampshire Medicaid Expenditures & Federal Medicaid Funding, FY 1997 - 2008, in millions of nominal dollars



Source: Centers for Medicare & Medicaid Services

- **Flexibility exists within the current system**.

In exchange for the federal financial support it provides, the federal government sets minimum eligibility and benefits standards for Medicaid that participating states must meet. States are allowed to provide optional benefits and to expand eligibility beyond those standards mandated by federal law – and most choose to do so. In fact, a significant majority of states' Medicaid spending is already optional, in that it covers populations and/or the benefits that states are allowed - but not required - to offer under federal law.[iv] Consistent with this trend, in FY 2010, New Hampshire spent $567.8 million on non-federally mandated benefits, or 56 percent of New Hampshire Medicaid's medical and provider payments.[v, vi] These services included (but were not limited to) home and community based care services, prescription drugs, durable medical equipment and medical supplies, optometric and audiological services, and ambulance services. While these benefits are nominally deemed "optional," they are central to the well-being of many members and assist them in remaining functional and independent.

The Impact of the Ryan Plan on New Hampshire

Under the proposal put forward by House Budget Chairman Paul Ryan (R-WI), instead of the federal government picking up a fixed percentage of states' Medicaid costs, no matter what the demand on the program is - as is current practice - the amount of federal funding available to the states would be capped, leaving New Hampshire, like all states, responsible for any and all remaining costs. In exchange for this funding limitation, and consistent with prior block grant proposals, states would likely be given additional flexibility to bypass many or all federal minimum requirements for eligibility and benefits.

According to the Center on Budget and Policy Priorities, total reductions to Medicaid, nationwide, for federal fiscal years 2013 through 2021 would equal $771 billion; ultimately, such reductions are expected to equal 35 percent of federal Medicaid funding, nationwide, by 2022 and 49 percent by 2030.[vii] As the table below shows, if the provisions of the Ryan Plan took effect, New Hampshire would lose approximately $2.8 billion in federal funding for Medicaid over the 2013-2021 period. Such losses would begin with an estimated reduction of $47.1 million in 2013 and would climb each year thereafter, reaching $264.4 million by 2016; additional cuts, equal $418 million per year, would occur from 2017 through 2021.[viii] All told, the reductions envisioned under the Ryan Plan would represent a loss of 24 percent of New Hampshire's federal Medicaid funding over the first ten years of the proposal.[ix] As the resolution put forward by Senator Patrick Toomey would reduce federal Medicaid funding by $326 billion more than the Ryan Plan, it would likely entail even greater federal funding losses for New Hampshire.

Ryan Plan Would Mean a Major Loss of Funds for New Hampshire
Projected Reductions in Federal Medicaid Funding for New Hampshire, 2013-2021

State Fiscal Year	2013	2014	2015	2016	2017 - 2021	TOTAL 2013 - 2021
Reduction in millions of dollars	$47.1	$163.0	$228.0	$264.4	$2,089.6	$2,792.2
Reduction as a percent of federal funding under current law	-5%	-17%	-22%	-24%	-31%	-24%

Source: NHFPI calculations based on data from Families USA and the Center on Budget and Policy Priorities

Under the Ryan Plan, the total block grant amount available to states each year would be adjusted annually by the rate of inflation plus the rate of population growth for the US as a whole. This annual adjustment would, on average, be 3.5 percentage points *less* than the current projected growth rate for the Medicaid program over the next 10 years.[x] Medicaid spending is projected to grow by an average annual rate of 6.4 percent, absent any increased spending due to recessions, pandemics, or the Affordable Care Act.[xi] Importantly, despite such anticipated program growth, Medicaid is still generally less costly than private sector plans, with Medicaid costing as much as 26 percent less per adult beneficiary than private insurance.[xii]

Thus, the Ryan Plan contains inherent and permanent shortfalls in funding. Federal funding would not keep pace with projected growth of the program, let alone

unexpected increases in costs. In a recession, when people lose their jobs and access to employer sponsored insurance, many become eligible for, and enroll in, Medicaid. Federal funding, in turn, rises to match such increased enrollment. For example, during the 2001 recession, Medicaid enrollment grew by 24 percent nationally between December 2000 and December 2003, reflecting losses of employment, incomes, and employer sponsored health insurance. States would not have received any additional funding during that downturn if the Ryan Plan had been in place in 2000.[xiii]

In short, New Hampshire would face substantial reductions to its federal Medicaid funding under the Ryan Plan, even under the best of circumstances. Worse still, in the event of the next inevitable economic downturn or public health crisis that drives up enrollment or costs in Medicaid, the state would bear most of the risks of higher-than-projected enrollment or higher-than-projected costs per person. The Ryan Plan thus shifts the funding risk of Medicaid onto the state and the people the Medicaid program serves: seniors, people with disabilities, poor children, and all of their families and communities.

The Impact of the McCaskill-Corker Proposal on New Hampshire

Under the proposal backed by Senators McCaskill and Corker, a permanent federal spending limit would force sharp reductions in federal Medicaid funding that likely could only be achieved by enacting changes similar to those contained in the Ryan Plan. Again, under such circumstances, New Hampshire would be responsible for costs beyond those permitted by a federal spending limit and likely would have to implement steep reductions in eligibility and benefits.

The McCaskill-Corker proposal would limit federal spending to 20.6 percent of gross domestic product (GDP) every year. Supporters note that the 20.6 percent target equals the average share of GDP that federal outlays represented over the last three decades of the previous century and the first years of this one. However, that average bears little relevance to the circumstances and obligations the nation will face in the decades ahead, including costs related to the aging of the population, heightened homeland security, the care of veterans returning from Iraq and Afghanistan, the implementation of the Medicare Part D drug benefit, and the extension of the 2001 and 2003 Bush tax cuts.[xiv]

Under the McCaskill-Corker proposal, automatic, across-the-board cuts to so-called entitlement programs, such as Medicare, Medicaid, and Social Security, would be used to close the gap between projected spending and the proposed cap, if the cap would be exceeded because policymakers had failed to reduce spending through other means. If these automatic cuts are triggered, spending in all entitlement programs would be reduced by the same percentage, which the Center on Budget and Policy Priorities calculates to be 19 percent by 2021. If the cuts needed to reach the cap were achieved entirely through automatic entitlement reductions, the estimated cuts to Medicaid alone would total $547 billion from 2013 through 2021, with increased reductions in subsequent years.[xv] Medicaid cuts would grow much larger in subsequent decades because the 20.6 percent cap would phase in gradually and not

take full effect until 2023. NHFPI estimates that, if these reductions are applied to the states in the same way the Ryan reductions are applied, New Hampshire could lose as much as $1.98 billion in federal Medicaid funding from 2013 through 2021 – or 17 percent of its federal funding for Medicaid during those years.

To be sure, elected officials in Washington could make the policy choices needed to reduce spending in order to comply with the proposed cap and thus to avoid automatic program cuts. However, given the level at which the cap would be set, as well as the share of the federal budget Medicare, Medicaid, Social Security, and other entitlements comprise, such policy choices would still entail enormous cuts in Medicaid.

Medicaid costs are projected to rise substantially in future decades due to the aging of a significant proportion of the population and rising health care costs. Thus, federal funding for Medicaid would have to be cut by increasingly steep amounts to meet the McCaskill-Corker spending limit. It is likely that in order to keep federal spending for Medicaid under the spending cap, policymakers would be forced to convert the program to a block grant, as the Ryan Plan would do, to ensure the federal government pays a predictable, fixed amount for Medicaid.

Potential Consequences for New Hampshire and its Medicaid Members

The challenges with funding Medicaid in the future arise both from increases in health care costs and the aging of a significant proportion of the population. Yet, neither the Ryan Plan nor the McCaskill-Corker proposal would address these root causes. Rather, these proposals shift the risk and the costs of providing care from the federal government to the states and by extension to seniors, people with disabilities, and poor children. If such proposals are enacted, the costs of providing care to these members will still exist; consequently, New Hampshire will have to pay more or make significant cuts to benefits or eligibility for seniors, poor children, and people with disabilities.

The Medicaid members most likely to be targeted for cuts are two groups that are relatively small as a share of program membership but that account for a sizable proportion of program costs: seniors and people with disabilities.

In the last fiscal year, seniors constituted 7 percent of the New Hampshire Medicaid population and 24 percent of its total medical and provider costs.[xvi] Medicaid expenditures for seniors in FY 2010 were more than $246 million. Medicaid covers services that Medicare does not, like long-term care services, including nursing home care. The Ryan and the McCaskill-Corker plans would require larger and larger Medicaid cuts over time, as health care costs rise and more seniors require Medicaid. In fact, the elderly population in New Hampshire is expected to rise sharply over the next 20 years, from 12.9 percent of New Hampshire residents today to 21.4 percent by 2030.[xvii]

Consequently, if either the Ryan or the McCaskill-Corker plans were given the force of law, long-term care services, while not likely to be eliminated outright, would undoubtedly be a target for substantial cuts. Long-term care services in New

Hampshire were the largest single category of Medicaid services spending in FY 2010, accounting for more than $512 million in expenditures for approximately 22,000 Medicaid members.[xviii] Reducing long-term care services could also mean reducing income eligibility for seniors – by making nursing home care unavailable to some lower income seniors, by establishing waiting lists for nursing home care, or by reducing the care for which the elderly in nursing homes are covered. The elderly could also be subjected to increased cost-sharing, especially those low-income Medicare members who currently receive help paying for their premiums and co-pays through the Medicaid program.

People with disabilities constituted a little more than 15 percent of New Hampshire Medicaid's members in FY 2010, but accounted for $458 million – or 45 percent – of its total medical and provider costs.[xix] A cap on federal Medicaid funding, as the Ryan plan would mandate and as the McCaskill-Corker plan would produce, would almost guarantee having to reduce eligibility and coverage for this vulnerable population, many of whom require extensive health care and long-term care services and may not be able to obtain insurance from other sources, either because of cost or because of the extent of their medical needs. People with disabilities in Medicaid programs frequently rely on services that states are allowed, but not required, to offer. Many people with disabilities rely both on benefits that prevent complications, which if untreated, may create the need for more expensive care, such as prescription drugs, durable medical equipment or physical therapy, and on benefits that help them live in the community, such as home and community based care. These services would likely be targets for spending reductions, if New Hampshire were to lose federal funds due to either the Ryan or the McCaskill-Corker plans, because, while the federal government does not mandate they be provided, it does extend funding for them, when a state elects to do so.

Reductions in eligibility and benefits will not erase the needs of New Hampshire residents who rely on New Hampshire Medicaid. Many of them will be unable to obtain insurance on the private market. As a result, their health care needs and costs would likely be shifted onto their families, providers, and local systems of care, should the federal government decide to reconsider its decades-long commitment to Medicaid.

[i] Center on Budget and Policy Priorities, "Toomey Budget Even More Radical, and Potentially More Damaging, Than Ryan Budget,"May 25, 2011, p. 2.
[ii] Kaiser Commission on Medicaid and the Uninsured, "House Republic Budget Plan: State-by-State Impact of Changes in Medicaid Financing," Holahan, Buettgens, Chen, Carroll & Lawton. May 2011, Tables 4, 5, & 6.
[iii] Data for 1997 through 2001 and 2002 through 2009 based on Federal Management Reports, CMS-64 Quarterly Reports, accessed at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp.
[iv] See for example, Kaiser Commission on Medicaid and the Uninsured, "Medicaid: An Overview of Spending on Mandatory vs. Optional Populations and Services," June 2005.
[v] Approximately 60 percent of state Medicaid spending is optional in that it consists of expenditures for the coverage of people and/or benefits federal law does not require them to cover. Center on Budget and Policy Priorities, "Ryan Medicaid Block Grant Would Cause Severe Reductions in Heath Care and Long-term Care For Seniors, People with Disabilities, and Children," May 3, 2011, p. 3. See also, Kaiser Commission on Medicaid and the Uninsured, "Medicaid: An Overview of Spending on Mandatory vs. Optional Populations and Services," June 2005.
[vi] Calculations based on Appendix 4a of Office of Medicaid Budget and Policy, New Hampshire Department of Health and Human Services, "New Hampshire Medicaid Annual Report State Fiscal Year 2010," April 20, 2011, p. 31-32.
[vii] Center on Budget and Policy Priorities,"What If Ryan's Medicaid Block Grant Had Taken Effect in 2000?" April 12, 2011, p. 1. Center on Budget and Policy Priorities, "Ryan Medicaid Block Grant Would Cause Severe Reductions in Heath Care and Long-term Care For Seniors, People with Disabilities, and Children," May 3, 2011, p. 1.
[viii] Families USA, "House Republicans Propose to Slash Funding for Medicaid, Medicare and Other Health Coverage Programs," Table 1, Page 4. April 2011.
[ix] Calculations based on the assumption that Medicaid spending will grow at an average annual rate rate of 6.4 percent, absent major changes to caseload or additional costs attributed to the Affordable Care Act. See Note x for more details on annual average growth rate.
[x] Center on Budget and Policy Priorities,"What If Ryan's Medicaid Block Grant Had Taken Effect in 2000?" April 12, 2011, p. 2.
[xi] Calculations by Center on Budget and Policy Priorities, based on US Congressional Budget Office (CBO) estimates of Medicaid baseline growth and with expenditure increases attributed to the ACA subtracted. See Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid"; "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, before the Subcommittee on Health Committee on Energy and Commerce U.S. House of Representatives March 30, 2011"; and "CBO's Budget and Economic Outlook FY 2011-2021," Table D4, p. 146 for more details. Sum of annual average CPI and average population growth is approximately 2.9 percent.
[xii] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* (web exclusive), June 24, 2008. See also Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?," *Inquiry* 40: 323-342, Winter 2003/2004.
[xiii] Center on Budget and Policy Priorities, "What If Ryan's Medicaid Block Grant Had Taken Effect in 2000?" April 12, 2011, p. 4, 5.
[xiv] Center on Budget and Policy Priorities, "Proposed Cap on Federal Spending Would Force Deep Cuts in Medicare, Medicaid, and Social Security," April 15, 2011, p. 4.
[xv] *Ibid*, p.1-2.
[xvi] Office of Medicaid Budget and Policy, New Hampshire Department of Health and Human Services, "New Hampshire Medicaid Annual Report, State Fiscal Year 2010," April 20, 2011, Table 4, p. 9.
[xvii]U.S. Census Bureau, State Interim Population Projections by Age and Sex: 2004 – 2030; Kaiser Commission on Medicaid, 2/2011
[xviii] Office of Medicaid Budget and Policy, New Hampshire Department of Health and Human Services, "New Hampshire Medicaid Annual Report, State Fiscal Year 2010," April 20, 2011, Table 5, p. 12,13.
[xix] *Ibid*, Table 4, p. 9.