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Medicaid, Sequestration, and the "Fiscal Cliff"

In the coming weeks and months, Congress and the White House will try to reach a deficit reduction agreement to avoid what observers have termed the "fiscal cliff" – the potential economic mess that could result from the combination of tax increases[1] and spending cuts currently scheduled to take effect at the beginning of January. Any deal to avoid the fiscal cliff is likely to have implications for the Medicaid program; a number of proposals currently being floated around Washington, DC, include spending cuts to Medicaid. This document details some of the key proposals that could negatively impact the Medicaid program.

Sequestration

In 2011, as part of a deal to avoid defaulting on the nation's debt, Congress passed the Budget Control Act (BCA). The BCA put into place a set of spending caps and created a special committee to create a plan to reduce the federal deficit by at least $1.2 trillion over the next ten years. The BCA also contained a provision that would trigger a projected $984 billion in across-the-board spending cuts, known as sequestration, in the event that the Super Committee failed to reach an agreement. The Medicaid program was specifically exempted from sequestration. Absent action by Congress between now and the end of 2012, the first installment of sequestration – an estimated $110 billion in cuts for fiscal year (FY) 2013 – is scheduled to take effect beginning January 2, 2013.

Threats to Medicaid

Because Medicaid is excluded from sequestration, it does not face any funding cuts should Congress fail to take further action before January 2. However, any deal to avert the fiscal cliff is likely to include reforms to entitlement spending, including Medicaid. While some of the proposals floated over the last year to achieve savings in Medicaid spending have the potential to reduce costs while not harming state programs or their patients, others have the potential to undermine the Medicaid program. A number of the current Medicaid proposals would shift risks and costs to states and reduce needed funding, which in turn would lead states to either cut benefits, lower Medicaid eligibility levels, or both.

Block Granting Medicaid

Block granting Medicaid would change the current federal/state partnership, in which states pay providers or managed care organizations and the federal government "matches" state dollars spent, to a system in which the federal government gives states a set amount of federal Medicaid funding each year.

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[1] On January 1, 2013, the Bush-era tax cuts are set to expire, including several that lower income and payroll taxes and limit the alternative minimum tax. An estimated 90% of Americans – including families making below $250,000 per year and families making above $250,000 – will see their taxes increase absent congressional action by the end of 2012.

Once that money is spent, the state is on its own. There would be no additional money provided in times of economic hardship, natural disaster, or other events that could increase health care costs or program enrollment. Additionally, block granting could put at risk protections for enrollees and providers, such as the current "freedom of choice" protections that allow enrollees to seek out Medicaid-funded family planning services at the provider of their choice.

Spending Caps

Medicaid funding today has no cap; the federal government provides states with as much money as they need to serve their eligible populations. Putting a payment cap on Medicaid as a means of reducing spending – which would limit the total amount the federal government can spend on Medicaid in a year – would mean that states would be on their own once the federal spending limit was reached.

Per Capita Cap

Some have proposed a per capita cap as an alternative to an overall spending cap. A per capita cap would limit the amount of money the federal government spends per enrollee in a state, rather than placing an overall cap on the total money the federal government spends on Medicaid in a year. This proposal, however, would have the same cost-shifting effect on states as an overall spending cap, locking states into per-beneficiary payment rates based on current costs and enrollment. This would be particularly problematic for states that decide to expand their Medicaid eligibility under the Affordable Care Act (ACA), as their per capita caps would be set before states had any data on the actual per-beneficiary costs of the newly eligible population.

Blended FMAP/Blended Rate

The federal government matches state dollars spent on the services provided through Medicaid in what is known as the Federal Medical Assistance Percentage, or FMAP. The national average FMAP is 57%, but differs from state to state. Additionally, along with a state's overall FMAP rate, the state receives different FMAP rates based on what population is being served and which services are being provided. Moving to a blended FMAP rate would replace the various matching rates at which the federal government reimburses states for their costs with a single blended rate for each state. Moving to a blended rate would supposedly save the federal government money in "administrative costs," but in reality would result in more cost-shifting to states. It is expected that a state's blended rate would be set at a level that provided the state with less federal funding than it currently receives, thus saving the federal government money. Additionally, the blended rate would be set based on current enrollment data, not taking into account changes in future services and populations served.

Reducing Funding for Medicaid Administrative Costs

There are proposals related to reducing Medicaid administrative costs, but the one thing all these proposals have in common is that they are designed to reduce how much the federal government spends on states' administrative costs, thereby shifting costs to states.