kaiser commission on medicaid and the uninsured

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National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid

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Executive Summary

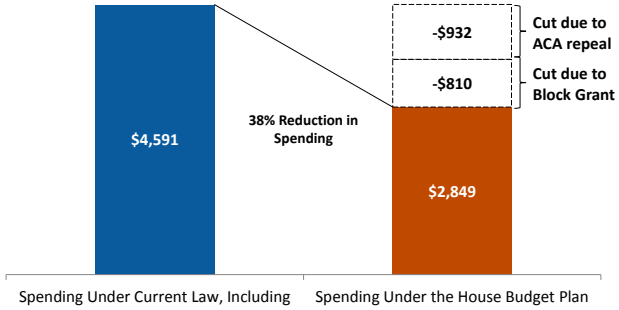
Federal deficit reduction is a key issue in the November 2012 elections, and debate over this issue will intensify throughout 2012 as federal policy makers try to avert automatic spending cuts effective January 2013 under the Budget Control Act. Policy leaders and fiscal commissions have put forth broad based deficit reduction plans. Many include changes to Medicaid, but they vary in magnitude. Medicaid is the nation's primary health coverage and long-term care program for low-income Americans. This paper examines the impact of the House Budget Plan for Medicaid, which passed along a party-line vote in April 2011 and again in 2012.

This analysis, conducted by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, updates our analysis from May 2011 and provides national and state-by-state estimates of the impact of the House Budget Plan. The plan includes two major provisions relevant to Medicaid. First, it would repeal the Affordable Care Act (ACA), which includes a major expansion of Medicaid with mostly federal funding to nearly all non-elderly individuals up to 138% of poverty. Second, it would convert Medicaid's structure from an entitlement with guaranteed federal matching payments to a block grant with capped federal funding to states. The block grant would start in 2013 and grow annually with population growth and inflation. The House Budget Plan for Medicaid is similar to Governor Romney's plan to repeal the ACA and convert Medicaid to a block grant increased each year by inflation plus 1%. Governor Romney estimates that his plan will save $100 billion annually. These changes would have significant implications for enrollees, states and providers.

Changes in Federal Spending. Under the House Budget Plan, federal Medicaid spending would be cut by $1.7 trillion over the 2013-2022 period. Of that total, $932 billion would come from the repeal of the ACA (assuming all states implemented the Medicaid expansion in the ACA) and another $810 billion due to the block grant. Together, these cuts represent a 38% total reduction in federal spending (ES Figure 1). The reductions in spending are expected to be smaller for states that currently have broad coverage and lower federal matching rates, and higher for states with a broader impact of the ACA and higher federal matching rate. We assume that all states implement the expansion because we are interested in state specific effects of repealing the ACA and do not know which states if any will not expand.

ES Figure 1

Federal Medicaid Spending Under Current Law and the House Budget Plan, 2013-2022

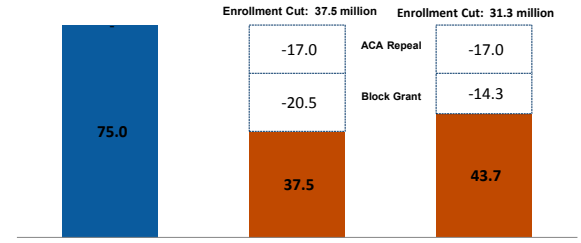


Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012

Potential Changes in Enrollment. The repeal of the ACA could reduce enrollment by 17 million. Since the growth of health care costs per enrollee within Medicaid is already relatively low, it would be difficult for states to maintain enrollment under lower federal payments. This analysis examines potential reductions in enrollment due to the block grant under two scenarios, each assuming that state spending is reduced proportionately to federal spending. First, if states maintain current spending per enrollee growth rates, reductions in enrollment could total 20.5 million. If states were able to limit per enrollee spending to rate of growth in GDP per capita (a growth rate rarely achieved by other payers), enrollment reductions could total 14.3 million (ES Figure 2). If there are no requirements that federal payments be matched by state contributions, states could reduce state spending more than federal spending and these enrollment estimates would be understated.

ES Figure 2

Medicaid Enrollment under Current Law and the House Budget Plan, 2022



	Current Law, Including ACA	Scenario 1: Assuming Current Per Enrollee Spending Growth	Scenario 2: Assuming Reduction in Per Enrollee Spending Growth
% Enrollment Cut from Repeal and Block Grant		50%	42%
% Enrollment Cut from Block Grant		35%	25%

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

Changes in State Spending to Offset Enrollment Cuts. States could avoid some of the enrollment cuts generated by the block grant by increasing spending from their own resources, but completely avoiding enrollment cuts would require very large increases in spending to offset the reduction in federal funds. Overall, increases in state spending would be 77% with no efficiency gains and 46% if Medicaid spending per enrollee was held to the rate of growth in GDP per capita.

Changes in Payments to Providers. Under the reductions from the block grant, payments to hospitals could fall by $363.8 billion and payments to nursing homes by $220.2 billion over the 2013 to 2022 period, a 22% reduction, assuming that states made cuts across the board. The impact of the block grant becomes increasingly steep over time; by 2022, payments to providers could fall by 32% relative to the baseline.

Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly and individuals with disabilities, financing long-term care services and supporting safety net providers. The House Budget Plan represents a fundamental change in the structure and financing of the Medicaid program from a program with an entitlement to coverage for individuals and a guarantee to states for federal matching dollars without a pre-set limit to a block grant. In addition, under current law, the program is set to be the foundation of coverage for low-income individuals under the ACA which would be repealed under the plan. The proposed changes and reductions in federal financing for Medicaid under the House Budget Plan would almost certainly worsen the problem of the uninsured and strain the nation's safety net. Medicaid's ability to continue these many roles in the health care system would be significantly compromised under this proposal, with no obvious alternative to take its place.

Methods

Developing state-by-state estimates of the House Budget Plan for Medicaid requires knowing what Medicaid enrollment and expenditures would be both with and without ACA. This requires several steps. First, we constructed a "pre- ACA" baseline of what Medicaid expenditures would be without the Affordable Care Act. This is based on CBO estimates at the national level of the impact of the ACA and of the ACA itself. We used these estimates to develop "pre-ACA" baselines for each state. Second, we developed estimates of the impact of the ACA Medicaid expansion by state, which enabled us to estimate the impact of ACA repeal. To gauge the full potential effect of repeal at the state level, we assume all states would have adopted the expansion and then examine the impact by state on coverage and federal expenditures. Third, we estimated state-by-state Medicaid spending under the growth rate assumptions embedded in the House budget proposal. For additional detail, see the full report.

Introduction

There has been a widespread debate in the United States over the size and the growth of the federal deficit. The President's National Commission for Fiscal Responsibility and Reform, together with Congressional committees, has wrestled with various approaches to reducing the deficit. Senators and Congressmen, as well as the Obama Administration, have made recommendations for reductions in spending and increases in revenues. The House Budget Committee, under Chairman Paul Ryan, has made its own comprehensive proposals for deficit reduction. Its prominent features include major changes to Medicaid and Medicare.[1] The House Budget Committee's proposals were passed by the House in 2011 and 2012 with Republican Party support, and it is similar to Governor Romney's plan for Medicaid.[2,3,4]

In this paper, we focus on the Medicaid provisions in the House Budget Plan. The plan would significantly reduce federal Medicaid spending and fundamentally alter the current entitlement structure and financing of the program. It would have significant implications for program beneficiaries, providers, states and localities. In this analysis we focus on assessing the potential effects of the House Budget Plan on Medicaid in terms of federal and state spending, enrollment, and providers (using hospitals and nursing homes as an example).

The House Budget Plan has two major provisions relevant to Medicaid. First, it would repeal the Affordable Care Act (ACA). The ACA includes several provisions, one of which is a major expansion of Medicaid, with mostly federal funding, to individuals with incomes up to 138% of the federal poverty line (FPL). The Medicaid expansion will significantly increase eligibility and enrollment among nonelderly adults, particularly adults without dependent children. With the Supreme Court decision in June 2012, states may decide to not expand their Medicaid programs. The repeal of the ACA could bring about substantial reductions in projected Medicaid enrollment and federal spending, though the precise impact of repeal could depend on which states take up the expansion. To gauge the full potential effect of repeal at the state level, we assume all states would have adopted the expansion and then examine the impact by state on coverage and federal expenditures.

Second, the House Budget Plan would convert the remaining Medicaid program to a block grant, ending the open ended federal matching rate system. Medicaid today (before the ACA Medicaid expansion goes into effect) provides health and long-term care coverage to approximately 55 million low-income Americans in an average month in 2012 including children, parents, individuals with disabilities and the elderly. [5] Under a block grant, federal spending would be capped annually and distributed to each state based on a formula rather than actual costs. Beginning in 2013, federal spending would be increased annually to keep up with population growth and inflation (CPI-U). Since both of these growth rates combined are below the expected rate of growth in Medicaid spending, the federal government would achieve significant savings. The proposal would give states additional flexibility to design their programs, though what federal requirements there would be for coverage, benefits or state-funding are not defined.

Our analysis shows that, under the House Budget Plan, federal Medicaid spending would decline substantially: $1.7 trillion over the 2013-2022 period, with $932 billion in savings from the repeal of the ACA and additional $810 billion in savings from the conversion to a block grant.

Reductions in federal payments present states with significant challenges. States have already had considerable success in containing the growth of health care costs per enrollee within Medicaid. Over the past decade, per enrollee Medicaid spending grew by less than 3% per year, below the growth in per capita gross domestic product (GDP).[6] One explanation is that the composition of Medicaid enrollees has shifted toward the lower-cost group of enrollees, e.g., adults and children, over time.[7] However, aggressive cost containment efforts by states were also important. Thus, while states would gain additional flexibility under the House proposed block grant, controlling Medicaid spending growth much below levels experienced in the past may be difficult to achieve. In their 2011 analysis of a previous, though largely similar, proposal, the Congressional Budget Office (CBO), noted that the large reduction in federal payments under the House Budget Plan would likely require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under "current law."[8]

In this analysis, we provide national and state-by-state estimates of changes in federal spending under the House Budget Plan. We estimate the impact due to both the elimination of the ACA and a conversion to a block grant. We then estimate the impact of the block grant on changes in Medicaid enrollment under two scenarios, each with a different growth rate of Medicaid spending per enrollee reflecting different assumptions about state success in containing costs given added flexibility. We then provide estimates of the increase in state expenditures that would be necessary to avoid any enrollment reductions from the block grant. We conclude with estimates of the impact from the block grant on the potential reductions in spending for hospitals and nursing homes – the largest category of Medicaid spending by service type.

Methods

Developing state-by-state estimates of the House Budget Plan for Medicaid requires knowing what Medicaid enrollment and expenditures would be both with and without ACA. This requires several steps. First, we constructed a "pre- ACA" baseline of what Medicaid expenditures would be without the Affordable Care Act. This is based on CBO estimates at the national level of the impact of the ACA. We used these estimates to develop "pre-ACA" baselines for each state. Second, we developed estimates of the impact of the ACA Medicaid expansion by state, which enable us to estimate the impact of ACA repeal. To gauge the full potential effect of repeal at the state level, we assume all states would have adopted the expansion and then examine the impact by state on coverage and federal expenditures. Third, we estimated state-by-state Medicaid spending under the growth rate assumptions embedded in the House budget proposal. Below we detail how we developed each of these sets of estimates.

1. "Pre-ACA" Baseline: To develop a pre-ACA baseline—that is, Medicaid spending independent of the ACA expansion—for the period 2013 through 2022, we began with the CBO baseline for current law including ACA.[9] We also used CBO estimates from March 2012 of the impact of the ACA for 2013 through 2022. Subtracting these ACA estimates from the current law including ACA baseline as of March 2012, we obtain a "pre-ACA" baseline. To translate the national totals into state specific estimates, we constructed baseline estimates for each state based on Medicaid Statistical Information System (MSIS) for 2007. We inflated the national 2007 MSIS numbers for each eligibility group (children, adults,

individuals with disabilities, and the elderly) to agree with CBO estimates of national spending and enrollment by eligibility group in 2013. We then inflated the MSIS data described above at the same rate as the pre-ACA baseline for 2013-2022. This means that each state would grow at the same rate over time but that differences in spending among states would be preserved over the period. That is, Massachusetts would have a high level of spending in this baseline because of their current policies and Texas would have a low level of spending in this baseline because of their current policies, but the baselines would grow at the same rate as each other and all other states. We used similar procedures for Medicaid spending on Medicare premiums, disproportionate share hospital (DSH) payments, and administration.[10]

2. ACA Medicaid Expansion Estimates: To estimate the impact of the ACA by state, we used the Urban Institute Health Insurance Policy Simulation Model (HIPSM) to simulate the impact of the ACA in 2014 to get estimates of the increase in Medicaid enrollment and expenditures in each state. These results were then grown over the 2013-2022 period using CBO's current law (including ACA) baseline for both enrollment and expenditures. The result is that each state's expenditures would grow under the ACA at the same rate as CBO's current law baseline, though from different starting points that reflect the state specific impact of the ACA. For example, the HIPSM simulation results show that Alabama would have a much bigger relative expansion under the ACA than New York because of its lower current Medicaid eligibility levels for adults. HIPSM also categorizes Medicaid enrollees by eligibility pathways, which allows us to apply differential matching rates for current eligibles, expansion eligibles, and new eligibles as specified under the law. It is important to note that state level enrollment and expenditure levels are grown such that national estimates also agree with CBO's current law ACA baseline at the national level between 2013 and 2022.

3. House Budget Plan: Estimating the impact of the House Budget Plan is done in two steps. The effect of repeal of the ACA is estimated by taking the difference between the baseline that includes the ACA Medicaid expansion (step 2) and our constructed pre-ACA baseline (step 1). Because both of these baselines are benchmarked to CBO estimates, the totals match national-level CBO estimates. Second, we estimated the impact of the House budget block grant assuming, as stated in the House budget proposal, that Medicaid spending would increase by population growth and by the CPI-U. This growth rate begins in 2011 and is projected through 2022. It was not applied until 2013 even though it begins growing from the 2011 expenditure base numbers.

To estimate the impact that this growth rate would have on enrollment, we examined two separate scenarios of spending growth per enrollee. In each we assume that states made proportional reductions in enrollment across population groups. We first assumed that states are not able to reduce Medicaid spending growth per enrollee below CBO projections of the pre-ACA baseline that is described above. Under that baseline, we calculate that spending per enrollee would grow at 5.7%, or GDP per capita plus 1.6%. Second, we assumed that states are able to reduce the growth in spending per enrollee to 4.1% per year or GDP per capita. Given these assumptions, we then asked how much enrollment would have to fall given the reduction in federal spending and assuming no increase in state spending.

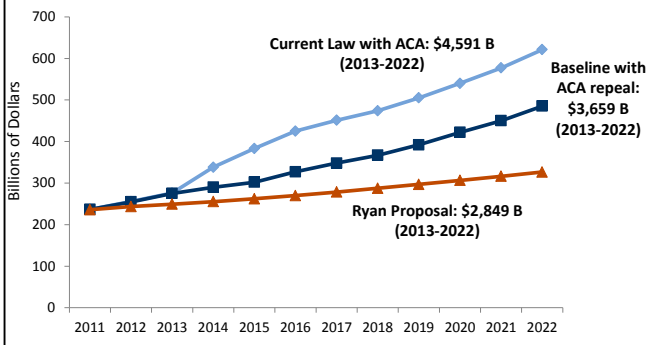
Results

Medicaid Spending Under the House Budget Plan

Spending Results for 2013-2022. Figure 1 summarizes our estimates of federal spending under current law and the major provisions of the House Budget Plan. Under current law, which includes the effects of the ACA and assumes all states adopt the Medicaid expansion, federal Medicaid spending totals to almost $4.6 trillion over the 2013 to 2022 period. If the ACA were repealed, we estimate that total federal spending for Medicaid over the same period would be about $3.7 trillion. Under the full House Budget Plan (including the ACA repeal and the block grant), our estimates indicate that total spending would fall to $2.8 trillion.

Figure 1

Federal Medicaid Spending Under Current Law and the House Budget Plan, 2013-2022



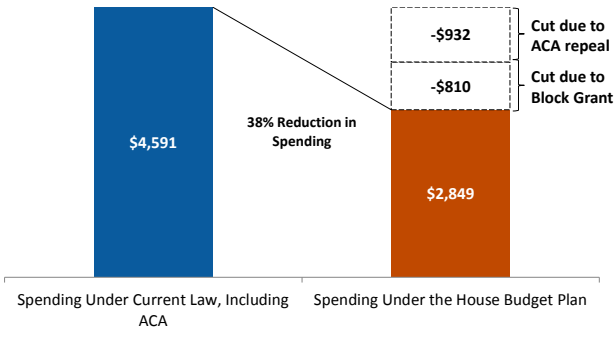
NOTE: The Ryan block grant does not come into effect until 2013 but begins growing from 2011 expenditure levels.
SOURCE: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012

Thus, compared with current law (the ACA fully implemented), federal Medicaid spending under the House Budget Plan would be $1.7 trillion less over the 2013-2022 period. The repeal of the ACA would save $932 billion (not counting offsetting savings from Medicare payment changes and other provisions). Note that this difference may actually be lower if some states do not adopt the Medicaid expansion; for example, CBO estimated that if several states did not adopt the Medicaid expansion projected federal spending with reform would only be $642 billion higher than under a pre-ACA baseline over 2013-2022.[11] Assuming that the ACA is repealed, the House Budget Plan would cut an additional $810 billion in federal Medicaid spending over the 2013—2022 period because the spending for the current Medicaid program is capped in the block grant.

Figure 2 shows the cumulative decrease in federal spending from 2013 to 2022 under the House Budget Plan. Table 1 compares federal Medicaid spending in each state under current law including ACA, under the pre-ACA baseline, and under the House Budget Plan. The reductions in spending with the repeal of the ACA amounts to a 20% decrease in expenditures nationally, assuming full implementation of the ACA expansion; however, the change in federal Medicaid spending under the repeal of ACA varies considerably among states because the

Figure 2

Federal Medicaid Spending Under Current Law and the House Budget Plan, 2013-2022



Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012

impact of the ACA varies considerably. States that already have substantial coverage, such as Vermont, the District of Columbia, Massachusetts, Minnesota, and Washington, would see relatively small decreases in federal spending if ACA were repealed. States with substantial enrollment increases because of the ACA together with high federal matching rates for those expansion populations, would see much larger decreases. For example, Florida, Georgia, and Texas would each see reductions in federal Medicaid spending relative to the ACA of about 30% or more if the law were repealed.

In addition to the ACA repeal, the House Budget Plan would further reduce federal Medicaid expenditures due to the block grant. Nationally, we estimate that the block grant represents a 22% decline relative to the pre-ACA baseline. So, even if a state does not implement the ACA Medicaid expansion, the cap on federal spending from the block grant represents a significant reduction in federal Medicaid contributions across all states relative to baseline spending (what spending would have been) without the ACA.

Our estimates of the state-by-state impact of the block grant are limited due to challenges in predicting differences in baseline spending growth across states. The House Budget Plan would increase federal Medicaid spending by a fixed rate (CPI plus population growth) that would grow by the same rate over time in all states. As stated above, we assume that all states would see spending growth equal to the increase in the national pre-ACA baseline. Thus the resulting reductions from the block grant would be the virtually same in all states. In reality, some states would actually grow faster and others more slowly than the national average. States that would have experienced higher growth rates than the national average under current law would experience sharper reductions in federal spending and vice versa. Although our results do not reflect this difference, we do capture some state level variation based on CBO projections for specific eligibility groups; to the extent that states have more aged and disabled than adults and children, they could see slightly different growth rates. Allowing growth rates to differ based on the eligibility pathway introduces small state-level variation based on the underlying distribution of enrollees.

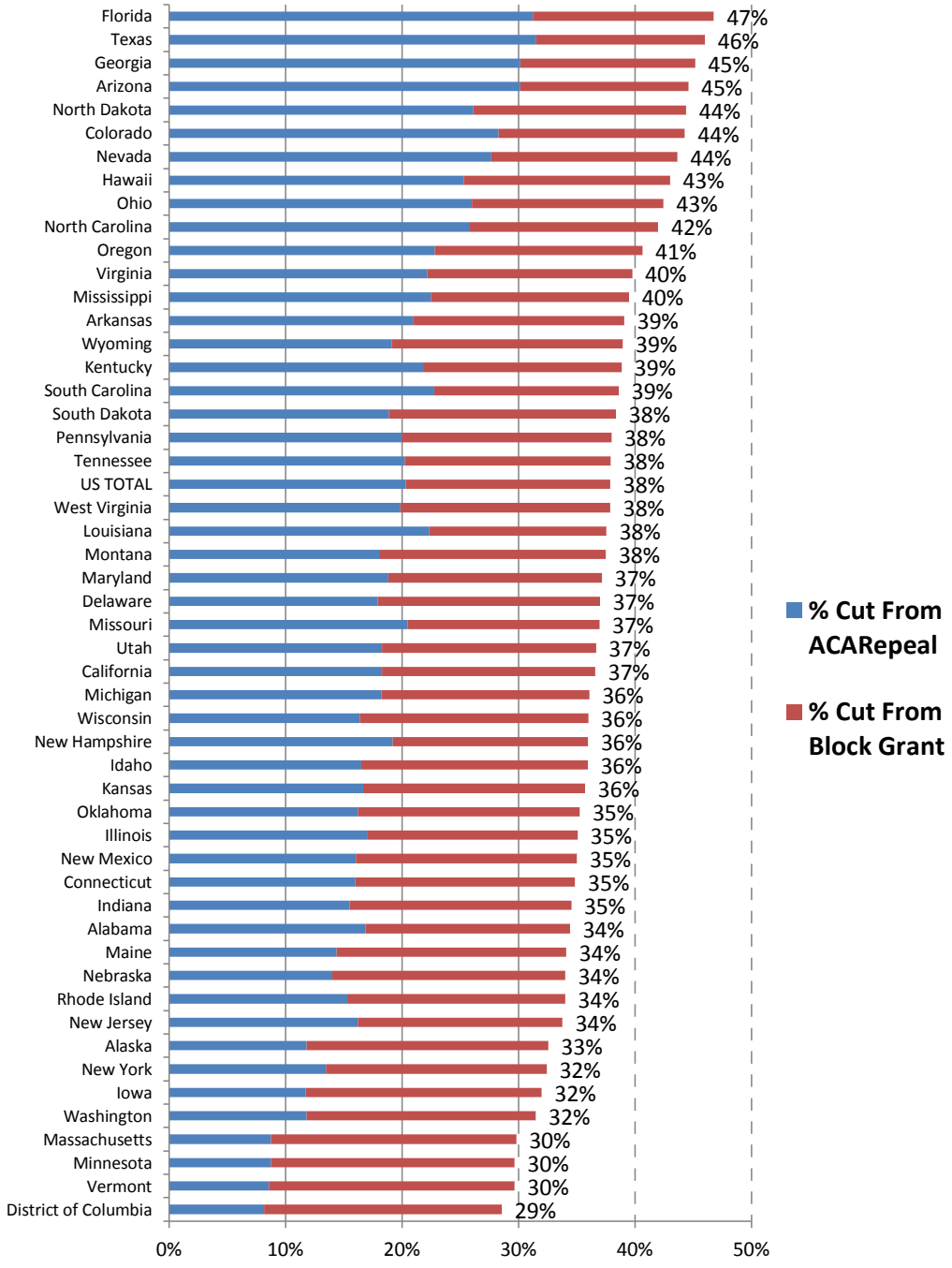
Combining the effects of the ACA repeal and of the block grant over the 2013 to 2022 period, our estimates indicate that enacting the House Budget Plan would reduce federal Medicaid spending by $1.7 trillion, or a reduction of 38% relative to full implementation of the ACA. Again, the estimated reductions in spending are smaller for states that currently have broad coverage and lower federal matching rates, and higher for states with a broader impact of the ACA and higher federal matching rate. The overall effect is very large in some states. For example, Florida, Texas, Georgia and Arizona could reductions in federal spending of 45% or more over the ten year period, and nine other states could have reductions of 40% or more. Figure 3 shows the combination of the effects of federal funding that states would lose from repeal of the ACA and the deeper reductions from the block grant applied to current coverage.

Table 1. Change in Federal Spending Under House Budget Plan for Years 2013-2022

State	Current Law Including ACA	Baseline with ACA Repeal	Reduction in Spending under Baseline due to ACA Repeal		Spending Under House Budget Plan	Reduction in Spending Under House Budget Plan Due to Medicaid Block Grant Only		Total Reduction In Spending Under House Budget Plan Due to ACA Repeal and Block Grant	
	$(billions)	$(billions)	Δ ($ billions)	Δ (%)	$(billions)	Δ ($ billions)	Δ (%)	Δ ($ billions)	Δ (%)
US TOTAL	**4,591**	**3,659**	**932**	**20%**	**2,849**	**810**	**22%**	**1,742**	**38%**
Alabama	62.7	52.1	10.6	17%	41.1	11.0	21%	21.6	34%
Alaska	13.1	11.6	1.6	12%	8.9	2.7	24%	4.3	33%
Arizona	104.9	73.3	31.7	30%	58.1	15.2	21%	46.8	45%
Arkansas	53.8	42.5	11.3	21%	32.7	9.8	23%	21.0	39%
California	464.3	379.4	84.9	18%	294.2	85.3	22%	170.2	37%
Colorado	43.9	31.5	12.4	28%	24.5	7.1	22%	19.5	44%
Connecticut	54.7	46.0	8.8	16%	35.6	10.4	23%	19.1	35%
Delaware	15.2	12.5	2.7	18%	9.6	2.9	23%	5.6	37%
District of Columbia	21.6	19.8	1.8	8%	15.4	4.4	22%	6.2	29%
Florida	213.8	147.0	66.8	31%	113.7	33.3	23%	100.1	47%
Georgia	120.6	84.2	36.4	30%	66.0	18.2	22%	54.5	45%
Hawaii	16.3	12.1	4.1	25%	9.3	2.9	24%	7.0	43%
Idaho	20.6	17.2	3.4	16%	13.2	4.0	23%	7.4	36%
Illinois	153.2	127.2	26.0	17%	99.4	27.8	22%	53.8	35%
Indiana	82.6	69.8	12.8	15%	54.0	15.8	23%	28.6	35%
Iowa	38.8	34.3	4.6	12%	26.4	7.9	23%	12.5	32%
Kansas	33.5	27.9	5.6	17%	21.5	6.4	23%	12.0	36%
Kentucky	81.1	63.4	17.7	22%	49.6	13.9	22%	31.6	39%
Louisiana	81.1	63.0	18.1	22%	50.6	12.4	20%	30.5	38%
Maine	31.4	26.9	4.5	14%	20.7	6.2	23%	10.7	34%
Maryland	68.4	55.6	12.9	19%	43.0	12.6	23%	25.5	37%
Massachusetts	109.6	100.0	9.6	9%	76.9	23.2	23%	32.7	30%
Michigan	128.6	105.1	23.5	18%	82.1	23.0	22%	46.5	36%
Minnesota	80.7	73.6	7.0	9%	56.7	16.9	23%	24.0	30%
Mississippi	61.3	47.5	13.8	22%	37.1	10.5	22%	24.3	40%
Missouri	95.1	75.6	19.5	20%	59.9	15.7	21%	35.2	37%
Montana	12.9	10.6	2.3	18%	8.0	2.5	24%	4.8	38%
Nebraska	23.0	19.8	3.2	14%	15.1	4.6	23%	7.8	34%
Nevada	20.6	14.9	5.7	28%	11.6	3.3	22%	9.0	44%
New Hampshire	16.2	13.1	3.1	19%	10.4	2.7	21%	5.8	36%
New Jersey	104.5	87.5	16.9	16%	69.1	18.4	21%	35.3	34%
New Mexico	45.3	38.1	7.3	16%	29.4	8.6	23%	15.9	35%
New York	541.3	468.5	72.8	13%	365.5	103.0	22%	175.8	32%
North Carolina	171.5	127.3	44.2	26%	99.3	27.9	22%	72.1	42%
North Dakota	10.5	7.7	2.7	26%	5.8	1.9	25%	4.7	44%
Ohio	224.0	165.7	58.3	26%	128.8	36.9	22%	95.2	43%
Oklahoma	52.7	44.2	8.6	16%	34.1	10.1	23%	18.6	35%
Oregon	49.6	38.3	11.3	23%	29.4	8.9	23%	20.2	41%
Pennsylvania	209.4	167.5	41.9	20%	129.7	37.8	23%	79.7	38%
Rhode Island	22.9	19.4	3.5	15%	15.1	4.3	22%	7.8	34%
South Carolina	68.9	53.2	15.7	23%	42.3	11.0	21%	26.6	39%
South Dakota	11.3	9.1	2.1	19%	6.9	2.2	24%	4.3	38%
Tennessee	119.6	95.4	24.2	20%	74.2	21.2	22%	45.4	38%
Texas	332.9	227.9	105.0	32%	179.6	48.3	21%	153.3	46%
Utah	26.9	22.0	4.9	18%	17.0	5.0	23%	9.9	37%
Vermont	13.2	12.0	1.1	9%	9.3	2.8	23%	3.9	30%
Virginia	67.1	52.2	14.9	22%	40.4	11.8	23%	26.7	40%
Washington	69.2	61.1	8.2	12%	47.4	13.7	22%	21.8	32%
West Virginia	42.0	33.7	8.4	20%	26.1	7.6	23%	15.9	38%
Wisconsin	76.9	64.3	12.6	16%	49.2	15.1	24%	27.7	36%
Wyoming	7.7	6.2	1.5	19%	4.7	1.5	25%	3.0	39%
Regional Totals[1]									
New England	248.0	217.4	30.6	12%	167.8	49.6	23%	80.1	32%
Middle Atlantic	960.5	811.5	149.0	16%	632.4	179.1	22%	328.1	34%
East North Central	665.2	532.1	133.1	20%	413.4	118.7	22%	251.8	38%
West North Central	292.8	248.1	44.7	15%	192.4	55.7	22%	100.4	34%
South Atlantic	683.8	497.6	186.2	27%	387.8	109.8	22%	296.1	43%
East South Central	324.8	258.5	66.3	20%	201.9	56.6	22%	122.8	38%
West South Central	520.5	377.6	142.9	27%	297.0	80.6	21%	223.5	43%
Mountain	282.9	213.7	69.1	24%	166.5	47.2	22%	116.4	41%
Pacific	612.6	502.5	110.1	18%	389.1	113.4	23%	223.5	36%

1. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MI, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

Figure 3: Percent Reduction in Spending Under House Budget Plan Due to ACA Repeal Combined With Medicaid Block Grant, 2013-2022



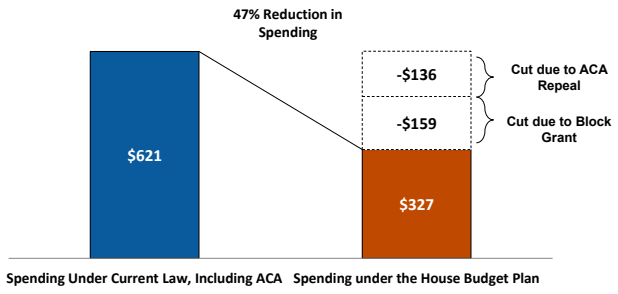
Note: Assumes all states implement the ACA Medicaid expansion
Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, June 2012.

Spending Results for 2022. Figure 4 and Table 2 show similar results for the year 2022. Because of increases in both enrollment and per enrollee spending, Medicaid spending under current law increases each year at a faster rate than the block grant. It is higher in 2022 in percentage terms relative to the baseline than it is cumulatively over the 2013-2022 period. Thus, in 2022, we estimate that the House Budget Plan would cut spending by 47% relative to current law. This total cut represents a 22% cut because of the repeal of the ACA and another 33% reduction in spending because of the block grant relative to the pre-ACA baseline.

The results for 2022 show a similar pattern in variation across states as the cumulative results for the 2013-2022 period. In 2022, states that gain the most coverage from the ACA would have the largest cuts in federal spending under the House Budget Plan and vice versa. Federal spending in the current law (ACA) baseline would be $621 billion. Federal spending in 2022 under the House plan will be $327 billion. The reductions in federal payments in 2022 would be $136 billion due to the ACA repeal and another $159 billion due to the block grant.

Figure 4

Federal Medicaid Spending Under Current Law and the House Budget Plan, 2022



Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

Table 2. Change in Federal Spending Under House Budget Plan for 2022

State	Current Law Including ACA	Baseline with ACA Repeal	Reduction in Spending under Baseline due to ACA Repeal		Spending Under House Budget Plan	Reduction in Spending Under House Budget Plan Due to Medicaid Block Grant Only		Total Reduction In Spending Under House Budget Plan Due to ACA Repeal and Block Grant	
	$(billions)	$(billions)	Δ ($ billions)	Δ (%)	$(billions)	Δ ($ billions)	Δ (%)	Δ ($ billions)	Δ (%)
US TOTAL	**621**	**485**	**136**	**22%**	**327**	**159**	**33%**	**295**	**47%**
Alabama	8.4	6.9	1.4	17%	4.7	2.2	32%	3.7	44%
Alaska	1.7	1.5	0.2	12%	1.0	0.5	34%	0.7	42%
Arizona	14.8	9.7	5.1	35%	6.7	3.0	31%	8.1	55%
Arkansas	7.2	5.6	1.5	21%	3.8	1.9	33%	3.4	48%
California	63.7	50.3	13.4	21%	33.7	16.6	33%	29.9	47%
Colorado	6.1	4.2	1.9	31%	2.8	1.4	33%	3.3	54%
Connecticut	7.1	6.1	1.0	14%	4.1	2.0	33%	3.0	43%
Delaware	2.0	1.7	0.4	18%	1.1	0.6	34%	0.9	46%
District of Columbi	2.8	2.6	0.1	5%	1.8	0.9	33%	1.0	36%
Florida	28.7	19.6	9.1	32%	13.0	6.6	33%	15.6	55%
Georgia	15.9	11.2	4.8	30%	7.6	3.6	32%	8.4	53%
Hawaii	2.3	1.6	0.6	29%	1.1	0.5	34%	1.2	53%
Idaho	2.7	2.3	0.5	17%	1.5	0.8	33%	1.2	45%
Illinois	20.5	16.8	3.7	18%	11.4	5.4	32%	9.1	44%
Indiana	11.0	9.2	1.7	16%	6.2	3.0	33%	4.8	44%
Iowa	5.2	4.5	0.6	12%	3.0	1.5	33%	2.2	42%
Kansas	4.5	3.7	0.8	17%	2.5	1.2	33%	2.0	45%
Kentucky	10.9	8.4	2.5	23%	5.7	2.7	32%	5.3	48%
Louisiana	11.0	8.3	2.7	24%	5.8	2.5	30%	5.2	47%
Maine	4.3	3.6	0.7	17%	2.4	1.2	34%	1.9	45%
Maryland	9.1	7.4	1.8	19%	4.9	2.4	33%	4.2	46%
Massachusetts	14.8	13.3	1.5	10%	8.8	4.5	34%	6.0	41%
Michigan	17.7	14.0	3.7	21%	9.4	4.6	33%	8.3	47%
Minnesota	10.9	9.7	1.1	10%	6.5	3.2	33%	4.4	40%
Mississippi	8.2	6.3	1.9	23%	4.2	2.1	33%	4.0	48%
Missouri	12.4	10.0	2.4	19%	6.9	3.2	31%	5.6	45%
Montana	1.7	1.4	0.3	19%	0.9	0.5	34%	0.8	47%
Nebraska	3.1	2.6	0.4	14%	1.7	0.9	34%	1.3	43%
Nevada	2.7	2.0	0.8	28%	1.3	0.6	33%	1.4	52%
New Hampshire	2.1	1.7	0.3	17%	1.2	0.5	31%	0.9	43%
New Jersey	14.0	11.6	2.4	17%	7.9	3.7	32%	6.1	43%
New Mexico	6.2	5.0	1.2	19%	3.4	1.7	33%	2.8	45%
New York	73.1	62.2	10.9	15%	41.9	20.3	33%	31.2	43%
North Carolina	22.4	16.8	5.6	25%	11.4	5.5	32%	11.0	49%
North Dakota	1.5	1.0	0.4	29%	0.7	0.4	35%	0.8	54%
Ohio	31.1	22.0	9.1	29%	14.8	7.2	33%	16.3	53%
Oklahoma	7.0	5.8	1.2	17%	3.9	1.9	33%	3.1	44%
Oregon	6.6	5.1	1.6	24%	3.4	1.7	34%	3.3	49%
Pennsylvania	28.9	22.3	6.6	23%	14.9	7.4	33%	14.0	48%
Rhode Island	3.1	2.6	0.5	18%	1.7	0.8	33%	1.4	45%
South Carolina	9.2	7.1	2.1	23%	4.8	2.2	31%	4.3	47%
South Dakota	1.5	1.2	0.3	19%	0.8	0.4	34%	0.7	47%
Tennessee	16.0	12.6	3.3	21%	8.5	4.1	33%	7.4	47%
Texas	46.5	30.2	16.3	35%	20.6	9.6	32%	25.9	56%
Utah	3.6	2.9	0.7	19%	2.0	0.9	33%	1.6	46%
Vermont	1.8	1.6	0.2	10%	1.1	0.5	33%	0.7	40%
Virginia	9.0	6.9	2.0	23%	4.6	2.3	33%	4.3	48%
Washington	9.4	8.1	1.3	14%	5.4	2.6	33%	3.9	42%
West Virginia	5.7	4.5	1.2	22%	3.0	1.5	33%	2.7	47%
Wisconsin	10.2	8.5	1.7	17%	5.6	2.9	34%	4.6	45%
Wyoming	1.0	0.8	0.2	22%	0.5	0.3	34%	0.5	49%
Regional Totals[1]									
New England	33.2	28.9	4.3	13%	19.2	9.6	33%	13.9	42%
Middle Atlantic	129.9	107.8	22.1	17%	72.5	35.3	33%	57.3	44%
East North Central	90.5	70.6	20.0	22%	47.4	23.2	33%	43.1	48%
West North Centra	39.0	32.9	6.1	16%	22.1	10.8	33%	16.9	43%
South Atlantic	90.9	66.0	24.8	27%	44.5	21.6	33%	46.4	51%
East South Central	43.5	34.3	9.3	21%	23.2	11.1	32%	20.4	47%
West South Centra	71.7	50.0	21.7	30%	34.1	16.0	32%	37.6	52%
Mountain	38.9	28.2	10.7	27%	19.1	9.1	32%	19.8	51%
Pacific	83.7	66.6	17.1	20%	44.6	22.0	33%	39.1	47%

1. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MI, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

Implications for Medicaid Enrollment Under the House Budget Plan

The House Budget Plan has several implications for Medicaid enrollment. First, by repealing ACA, enrollment would be lower than under current law due to loss of eligibility for those enrolled in Medicaid under the expansion (assuming all states implement the Medicaid expansion). Second, states will have to operate their "pre-ACA" programs under tighter budgets. In the face of reduced federal spending for Medicaid, states will face difficult policy choices. States will likely attempt to reduce spending and improve program efficiency, but they may also need to reduce enrollment to operate within more limited total Medicaid budgets. For example, to avoid enrollment cuts, states would have to reduce spending per enrollee on average by 22% over the 2013-2022 period and by 33% in 2022.[12] Increasing program efficiency to this extent will be very difficult because states have already adopted many aggressive policies to control spending levels and growth and Medicaid per capita spending is already lower than private per capita spending[13]. The program is frequently criticized for its low provider payment rates and low rates of physician participation. Thus, the most likely areas for making substantial spending reductions are benefits or eligibility. In this section, we examine the potential impact on enrollment in 2022 due to the repeal of ACA and the block grant. We estimate the impact of the block grant under two scenarios.

Under the first scenario, we assume that states maintain per person spending at rates equal to those projected under our pre-ACA baseline, which is equal to GDP per capita plus 1.6% (or GDP plus 0.6%). In many discussions of deficit reduction, linking spending to the rate of growth in GDP per capita plus 1.0% or to GDP is frequently cited as a goal. CBO projections suggest that states are currently close to those levels.[14] We first examine what it would mean for states to continue to spend at those growth rates.

Under the second scenario, we alternatively make the assumption that states could achieve a fair degree of success in controlling spending growth -- that states will be able to control spending growth to GDP per capita. This is a level of spending restraint that private and public payers have rarely achieved. We assume that states will achieve these growth rates by finding ways to increase program efficiency and then examine how much more would need to be achieved through enrollment cuts.

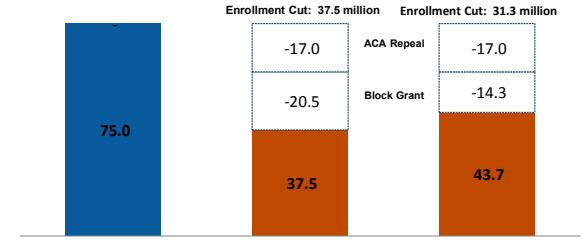
Enrollment reductions would likely affect children, because they are a disproportionate share of Medicaid enrollment. There is significant variation in eligibility levels for adults across states. Most states do not cover childless adults through Medicaid today. Over half the states set the eligibility for working parents with incomes below 100% of FPL, in 17 states it is below 50% of FPL.[15] For many of these states it would be extremely difficult to reduce eligibility levels by these amounts. In these circumstances, states could cap enrollment and use waiting lists.

In each of these scenarios, we assume that state spending is reduced by the same percentage as federal spending; that is, we did not assume that states would increase spending to offset reductions in federal spending. Figure 5 summarizes the national results under these scenarios, and Table 3 provides state-by-state results. Note that the estimates of enrollment cuts are subject to state actions under the block grant. For example, if the states increase their Medicaid spending to compensate for the loss of federal dollars, then the need for enrollment cuts would be much less. However, if states decide to spend less of their own dollars (for example, if there are no federal requirements that federal payments be matched by state contributions), they could cut state spending even more than federal spending and these

enrollment estimates would be understated. The federal requirements related to state matching requirements are not specified in the House Budget Plan.

Figure 5

Medicaid Enrollment under Current Law and the House Budget Plan, 2022



	Current Law, Including ACA	Scenario 1: Assuming Current Per Enrollee Spending Growth	Scenario 2: Assuming Reduction in Per Enrollee Spending Growth
% Enrollment Cut from Repeal and Block Grant		50%	42%
% Enrollment Cut from Block Grant		35%	25%

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

Scenario 1: Current Law Per Person Spending is Maintained

In the first scenario, Medicaid spending per enrollee would grow at the rates currently projected under our pre-ACA baseline, which is based on CBO estimates of Medicaid growth if ACA had not been enacted. This growth rate equals an average increase in spending per enrollee of 5.7%, or GDP per capita plus 1.6 percentage points. Because federal payments would grow more slowly under the House Budget Plan than under our pre-ACA baseline, and because there are no more efficiency gains under this scenario, all of the spending reductions would have to come from cuts in enrollment. We assumed that the cuts would be spread equally across all eligibility groups – the aged and disabled as well as nondisabled adults and children. Were the aged and disabled to be exempted from cuts, cuts to nondisabled adults and children would have to be disproportionately larger, since much less is spent on them per capita. We estimated the cuts in enrollment by taking total (state and federal) projected Medicaid spending in a year, with both the baseline and House Budget Plan, dividing each by spending per enrollee for each year and deriving the change in the number of enrollees that could be covered at that spending level.

Under current law, including the ACA, we estimate that average monthly Medicaid enrollment would be 75 million in 2022 (Figure 5). Repealing the ACA could reduce enrollment in 2022 by about 17 million, or 23%. Similarly to changes in spending, predicted reductions in enrollment are greatest in states with the greatest coverage expansion under the ACA such as Florida, Georgia, Texas, and several other states in the South and West (Table 3).

With the ACA repeal, there would be about 58 million Medicaid enrollees on an average monthly basis. We estimate that under the scenario in which Medicaid spending per enrollee grows at GDP per capita plus 1.6%, Medicaid enrollment would be cut by an additional 20.5 million low-income Americans. As a

share of enrollment, the conversion of Medicaid into a block grant program could result in a 35% reduction in enrollment relative to projected enrollment even without the ACA. Combining the effects of the ACA repeal and the block grant, we estimate that 37.5 million individuals could no longer be enrolled in Medicaid compared to the number that would be enrolled under current law, a 50% reduction.

Scenario 2: Reductions in per Person Spending

The second scenario is that states would achieve substantial efficiencies and reduce the rate of growth in spending per enrollee to GDP per capita. By slowing down the rate of growth in spending per enrollee, enrollment cuts would be necessary but would be less drastic than under the first scenario. Achieving this rate of growth in spending per enrollee is rarely achieved by either public or private payers, but it is useful to examine this scenario as it is a commonly-stated goal. As in the first scenario, we estimated cuts in enrollment by taking total (state and federal) projected Medicaid spending in a year in both the baseline and House Budget Plan and dividing this spending by the assumed lower level of growth in spending per enrollee to derive the change in the number of enrollees that could be covered at those spending levels. We also assume that enrollment cuts are spread equally across all eligibility groups.

The impact of the ACA repeal on enrollment holds regardless of the growth rate assumed, since this cut is due to eligibility loss. Thus, the 17 million losing coverage due to the ACA repeal holds. Under the lower growth rate in spending for the remaining program, we estimate that states will still need to reduce enrollment by 14.3 million under the House block grant proposal. Together with the impact of the ACA repeal, we estimate that Medicaid enrollment would fall by 31.3 million (Figure 5). This is a 25% from the block grant relative to the pre-ACA baseline and a 42% reduction relative to full ACA implementation. The largest percentage reductions would be in the states that gain the most from the ACA (Table 3).

Table 3. Potential Change in Enrollment Under House Budget Plan, Assuming Cuts are Spread Among All Groups, 2022

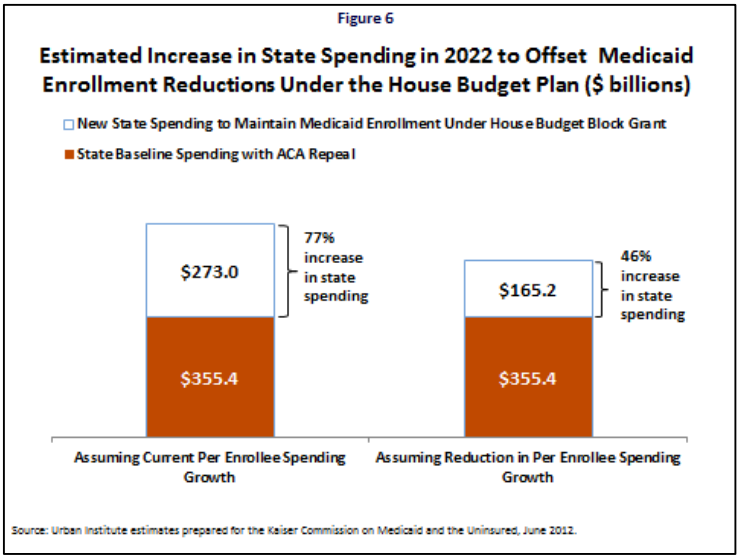
	Enrollment Under Current Law Including ACA	Reduction in Enrollment Due to ACA Repeal		Baseline Enrollment With ACA Repeal	Potential Reduction in Enrollment from Block Grant to Medicaid				Total Reduction in Enrollment from ACA Repeal and Block Grant	
Growth Rate:					*GDP per capita +1.6%*		*GDP per capita*		*GDP per capita + 1.6%*	*GDP per capita*
State	(thousands)	Δ (thousands)	Δ (%)	(thousands)	Δ (thousands)	Δ (%)	Δ (thousands)	Δ (%)	Δ (thousands)	Δ (thousands)
US TOTAL	**75,005**	**17,010**	**23%**	**57,995**	**20,537**	**35%**	**14,253**	**25%**	**37,547**	**31,263**
Alabama	1,249	323	26%	926	329	36%	225	24%	651	548
Alaska	160	40	25%	120	39	33%	25	21%	79	65
Arizona	1,625	326	20%	1,299	428	33%	289	22%	754	615
Arkansas	935	242	26%	693	251	36%	177	26%	493	419
California	12,537	2,124	17%	10,413	3,918	38%	2,742	26%	6,042	4,866
Colorado	805	253	31%	552	194	35%	133	24%	447	386
Connecticut	657	130	20%	528	185	35%	128	24%	315	258
Delaware	212	28	13%	184	63	34%	43	23%	91	70
District of Columbia	197	30	15%	167	61	36%	42	25%	90	72
Florida	4,195	1,353	32%	2,841	1,004	35%	707	25%	2,357	2,061
Georgia	2,406	726	30%	1,680	597	36%	410	24%	1,323	1,136
Hawaii	282	67	24%	215	76	35%	52	24%	143	119
Idaho	307	94	31%	213	77	36%	53	25%	171	147
Illinois	2,979	670	22%	2,309	796	34%	549	24%	1,466	1,219
Indiana	1,391	371	27%	1,020	367	36%	257	25%	738	628
Iowa	543	73	13%	470	162	35%	113	24%	235	185
Kansas	534	180	34%	354	125	35%	86	24%	305	266
Kentucky	1,129	280	25%	848	294	35%	204	24%	574	484
Louisiana	1,505	406	27%	1,099	382	35%	254	23%	788	659
Maine	399	47	12%	352	127	36%	89	25%	174	136
Maryland	998	170	17%	828	294	36%	206	25%	464	376
Massachusetts	1,521	77	5%	1,444	506	35%	358	25%	583	435
Michigan	2,285	424	19%	1,861	648	35%	449	24%	1,072	874
Minnesota	908	123	14%	785	278	35%	196	25%	401	319
Mississippi	992	236	24%	757	267	35%	186	25%	503	421
Missouri	1,410	405	29%	1,005	357	36%	243	24%	763	648
Montana	180	69	38%	111	41	37%	28	25%	110	97
Nebraska	337	97	29%	240	88	37%	61	25%	185	158
Nevada	404	158	39%	247	87	35%	58	24%	245	216
New Hampshire	191	47	25%	143	50	35%	32	22%	97	79
New Jersey	1,287	333	26%	954	439	46%	299	31%	772	632
New Mexico	656	159	24%	497	178	36%	124	25%	337	283
New York	5,550	606	11%	4,944	1,699	34%	1,178	24%	2,305	1,784
North Carolina	2,269	620	27%	1,649	583	35%	405	25%	1,203	1,025
North Dakota	104	34	33%	69	25	36%	16	24%	59	51
Ohio	2,819	744	26%	2,075	729	35%	512	25%	1,473	1,256
Oklahoma	929	213	23%	716	256	36%	179	25%	469	392
Oregon	810	297	37%	513	192	37%	135	26%	489	432
Pennsylvania	2,726	602	22%	2,124	761	36%	536	25%	1,364	1,139
Rhode Island	242	44	18%	197	69	35%	46	24%	113	91
South Carolina	1,218	326	27%	892	313	35%	212	24%	639	538
South Dakota	169	47	28%	122	45	37%	30	25%	91	77
Tennessee	1,859	399	21%	1,460	502	34%	349	24%	901	748
Texas	6,102	1,966	32%	4,136	1,458	35%	999	24%	3,424	2,966
Utah	436	147	34%	290	103	36%	71	24%	250	218
Vermont	165	8	5%	157	53	34%	36	23%	61	44
Virginia	1,218	352	29%	866	301	35%	210	24%	653	562
Washington	1,324	161	12%	1,163	432	37%	301	26%	593	461
West Virginia	518	117	23%	401	142	35%	99	25%	259	216
Wisconsin	1,226	239	19%	987	355	36%	253	26%	593	492
Wyoming	105	27	26%	78	26	34%	16	21%	53	44
Regional Totals[1]										
New England	3,175	353	11%	2,822	989	35%	688	24%	1,343	1,042
Middle Atlantic	10,970	1,769	16%	9,201	3,212	35%	2,230	24%	4,981	3,999
East North Central	10,701	2,448	23%	8,253	2,895	35%	2,022	24%	5,343	4,470
West North Central	4,004	959	24%	3,045	1,080	35%	747	25%	2,039	1,706
South Atlantic	11,824	3,495	30%	8,329	2,936	35%	2,044	25%	6,431	5,538
East South Central	5,228	1,237	24%	3,991	1,390	35%	963	24%	2,627	2,200
West South Central	9,471	2,827	30%	6,644	2,348	35%	1,610	24%	5,174	4,437
Mountain	4,518	1,233	27%	3,286	1,140	35%	777	24%	2,372	2,010
Pacific	15,113	2,689	18%	12,424	4,647	37%	3,242	26%	7,337	5,931

1. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MI, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

Impacts on State Spending to Preserve Eligibility

In this section, we estimate how much state expenditures would have to increase if states wanted to avoid enrollment reductions under lower levels of federal Medicaid spending. These estimates assume the repeal of the ACA as a given and that states would only be attempting to offset the loss in federal revenues because of the block grant. The results are shown in Table 4 and Figure 6. States would have to increase spending substantially to avoid cuts in enrollment or for providers. State spending under pre-ACA baseline (with ACA repeal) in 2022 would be $355.4 billion.

Figure 6



Under the assumption that states cannot reduce spending per enrollee below GDP per capita plus 1.6%, the current projected rates of growth, then state spending would need to increase by $273.0 billion, or 77% (Figure 6). Increases would generally be greatest in states with the higher federal matching rates (Table 4). For example, Mississippi would have to increase spending by 131% and West Virginia by 124%. This occurs because the federal government is currently paying a high share of Medicaid spending in such states. Thus, many states in the South and West would have to more than double their current spending from their own revenues on Medicaid to avoid enrollment cuts. Conversely, states with the lowest match rates, 50%, tend to show lower required increases in state spending to avoid enrollment cuts, all else being equal. If states were able to reduce spending growth to GDP per capita, they would still need to spend an additional $165.2 billion to avoid enrollment reductions. This would be a 46% increase in spending over current levels. Again, the increases would be the greatest in states with higher federal matching rates, generally in the South and West. This additional state spending would be replacing reductions in federal funding and unlike the current financing structure, additional state spending would not generate additional federal matching dollars.

Table 4. Potential Impact of Block Grant and Enrollment Cuts on State Expenditures, 2022

	State Expenditures Under Baseline With ACA Repeal	New State Spending to Avoid Enrollment Cuts Due to Block Grant			
Growth Rate:		*GDP per capita + 1.6%*		*GDP per capita*	
	($ billions)	Δ ($ billions)	Δ (%)	Δ ($ billions)	Δ (%)
US TOTAL	**355.4**	**273.0**	**77%**	**165.2**	**46%**
Alabama	3.0	3.2	105%	1.9	63%
Alaska	1.3	0.8	63%	0.4	34%
Arizona	4.6	4.4	97%	2.6	57%
Arkansas	2.2	2.6	118%	1.6	72%
California	48.6	32.5	67%	19.9	41%
Colorado	3.9	2.6	66%	1.6	39%
Connecticut	5.8	3.9	67%	2.3	40%
Delaware	1.2	0.9	72%	0.5	42%
District of Columbia	1.0	1.2	112%	0.7	67%
Florida	14.8	11.4	77%	7.0	48%
Georgia	5.5	5.3	97%	3.2	58%
Hawaii	1.4	0.9	67%	0.6	40%
Idaho	0.9	1.0	116%	0.6	70%
Illinois	16.3	10.6	65%	6.4	39%
Indiana	4.4	4.5	102%	2.7	62%
Iowa	2.7	2.4	86%	1.4	52%
Kansas	2.6	2.0	78%	1.2	47%
Kentucky	3.3	3.8	115%	2.3	70%
Louisiana	5.1	4.1	80%	2.4	46%
Maine	1.9	1.8	93%	1.1	57%
Maryland	7.1	4.8	67%	2.9	41%
Massachusetts	12.8	8.7	68%	5.4	42%
Michigan	6.9	6.8	99%	4.1	60%
Minnesota	9.4	6.4	68%	3.9	42%
Mississippi	2.1	2.7	131%	1.7	79%
Missouri	5.6	4.9	88%	2.9	52%
Montana	0.6	0.6	104%	0.4	62%
Nebraska	1.9	1.4	78%	0.9	47%
Nevada	1.4	1.0	74%	0.6	43%
New Hampshire	1.5	0.9	61%	0.5	34%
New Jersey	11.2	7.2	64%	4.3	38%
New Mexico	2.1	2.3	110%	1.4	67%
New York	59.9	39.6	66%	23.9	40%
North Carolina	8.7	8.3	95%	5.1	58%
North Dakota	0.7	0.5	76%	0.3	44%
Ohio	12.0	11.3	94%	6.9	57%
Oklahoma	3.2	3.0	94%	1.8	57%
Oregon	2.8	2.6	92%	1.6	56%
Pennsylvania	17.6	13.3	75%	8.1	46%
Rhode Island	2.2	1.5	68%	0.9	40%
South Carolina	2.9	3.1	108%	1.8	64%
South Dakota	0.7	0.6	83%	0.4	49%
Tennessee	6.2	6.1	99%	3.7	60%
Texas	21.1	16.3	78%	9.8	46%
Utah	1.1	1.3	116%	0.8	70%
Vermont	1.0	0.8	79%	0.5	46%
Virginia	6.6	4.4	67%	2.7	41%
Washington	7.8	5.2	66%	3.1	40%
West Virginia	1.6	2.0	124%	1.2	75%
Wisconsin	5.4	4.7	88%	2.9	55%
Wyoming	0.7	0.4	64%	0.2	35%
Regional Totals[1]					
New England:	25.3	17.6	70%	10.7	42%
Middle Atlantic:	98.1	66.9	68%	40.5	41%
East North Central:	44.9	37.9	84%	23.1	51%
West North Central:	23.6	18.3	77%	11.0	47%
South Atlantic:	40.1	34.6	86%	21.0	52%
East South Central:	14.6	15.8	108%	9.6	66%
West South Central:	31.6	26.0	82%	15.6	49%
Mountain:	15.3	13.8	90%	8.2	54%
Pacific:	61.9	42.1	68%	25.6	41%

1. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MI, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

Impacts on Hospitals and Nursing Homes from the Block Grant

This section examines the potential impact of the block grant on hospitals and nursing homes, the largest Medicaid providers. Nationally, hospitals and nursing homes account for 26% and 16% of Medicaid spending, respectively.[16] Unlike previous analysis, these results include both federal and state spending. Further, we only look at the impact of the block grant and do not assess the impact of the repeal of ACA.

To develop these estimates, we determined the share of Medicaid spending that goes to hospitals and nursing homes, respectively, based on the 2007 MSIS. We then projected hospital and nursing home spending in each state, assuming that hospital and nursing home share of total spending remains the same over the 2013 to 2022 period. Thus the share of spending on hospitals and nursing homes will vary among states depending on each state's starting point. We assumed that states would reduce their own spending at the same rate as federal reductions. We then estimate reductions in hospital and nursing home expenditures over the period 2013 to 2022, assuming that states would make equal reductions across providers. Note that we assumed that these cuts to providers could occur through both enrollment reductions as well as through payment or benefit policies.

Under the block grant provisions of the House Budget Plan, we estimate that there could be a reduction of $363.8 billion in payments to hospitals between 2013 and 2022 (Table 5). As with the total federal spending impact, the reduction over the period is 22% in virtually all states, again because we assumed the same growth rate in the pre-ACA baseline in all states and because the block grant formula applies equally to all states. In 2022, hospitals could see reductions of $71.5 billion, or a 32% reduction (data not shown) relative to the 2022 pre-ACA baseline.

Table 5 also shows the same results for nursing homes. The reductions in payments to nursing homes over the period would amount to $220.2 billion. Again, the percentage reduction is about 22% in all states because we assumed that payment reductions would affect all providers equally. Payments to nursing facilities could be lower by $43.3 billion in 2022; the percentage reduction could be 32% by 2022 because the cuts in the block grant relative to the baseline increase over time (data not shown). Reductions in payments to nursing homes of this amount would be quite significant since Medicaid accounts for about 40% of the nation's nursing home spending.[17]

Managed care plans, home and community based services, and others will see payment reductions in a similar range of about 22% from the block grant over the 2013 to 2022 period, and about 33% by 2022 (data not shown). It is possible that states would disproportionately cut some services, particularly services that are now optional. Services, such as physician and clinic services, prescription drugs, institutional care for the intellectually disabled and mentally ill, are difficult to cut. It would require enormous cuts in remaining benefits to avoid substantial cuts in hospital and nursing home spending. Thus, these estimates may reflect an upper band of potential reductions to hospitals and nursing homes under the block grant proposal, but not substantially so. Similar to the analysis above, states could mitigate reductions in payments to providers by increasing state spending to offset the reduction in federal spending.

Table 5. Potential Impact of House Budget Plan on Federal and State Medicaid Payments to Hospitals and Nursing Facilities, 2013-

	Medicaid Payments to Hospitals			Medicaid Payments to Nursing Homes		
	Basline with ACA Repeal $(billions)	House Budget Plan $(billions)	Effect of Block Grant under House Budget Plan Δ ($billions)	Basline with ACA Repeal $(billions)	House Budget Plan $(billions)	Effect of Block Grant under House Budget Plan Δ ($billions)
US TOTAL	**1,659.2**	**1,295.4**	**363.8**	**1,004.5**	**784.2**	**220.2**
Alabama	8.1	6.4	1.7	17.8	14.0	3.7
Alaska	4.7	3.9	0.8	1.6	1.3	0.3
Arizona[1]	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	10.7	8.3	2.5	11.2	8.6	2.6
California	181.8	141.1	40.7	92.1	71.4	20.6
Colorado	15.2	12.0	3.2	10.0	7.8	2.1
Connecticut	13.4	10.5	2.9	22.0	17.2	4.7
Delaware	5.5	4.4	1.1	3.3	2.6	0.7
District of Columbia	7.9	6.2	1.7	2.7	2.1	0.6
Florida	84.8	65.5	19.3	47.1	36.4	10.7
Georgia	44.9	35.2	9.6	20.9	16.4	4.5
Hawaii	7.6	6.0	1.6	1.7	1.4	0.4
Idaho	5.5	4.3	1.2	3.0	2.3	0.7
Illinois	87.2	68.2	19.0	31.9	24.9	6.9
Indiana	22.2	17.2	5.0	19.4	15.0	4.4
Iowa	10.9	8.5	2.4	8.9	7.0	2.0
Kansas	10.8	8.4	2.3	7.6	5.9	1.7
Kentucky	23.8	18.6	5.2	15.0	11.7	3.3
Louisiana	26.0	20.9	5.1	12.8	10.3	2.5
Maine	3.9	3.0	0.9	5.8	4.5	1.3
Maryland	34.2	26.4	7.7	19.4	15.0	4.4
Massachusetts	48.9	37.7	11.2	33.7	26.0	7.7
Michigan	51.1	40.0	11.1	28.7	22.4	6.2
Minnesota	33.2	25.5	7.6	17.2	13.3	4.0
Mississippi	18.4	14.4	4.0	12.6	9.9	2.8
Missouri	33.8	26.8	7.0	16.3	12.9	3.4
Montana	2.8	2.2	0.6	3.8	3.0	0.8
Nebraska	7.0	5.4	1.5	6.8	5.3	1.5
Nevada	5.7	4.5	1.1	3.4	2.7	0.7
New Hampshire	2.9	2.4	0.5	5.8	4.7	1.0
New Jersey	35.2	27.9	7.3	40.3	32.0	8.3
New Mexico	21.9	16.9	4.9	1.0	0.8	0.2
New York	220.8	172.8	48.0	142.5	111.5	31.0
North Carolina	41.8	32.5	9.3	22.1	17.2	4.9
North Dakota	1.7	1.4	0.3	4.0	3.2	0.8
Ohio	59.7	46.2	13.5	53.5	41.4	12.1
Oklahoma	17.9	13.8	4.0	9.4	7.2	2.1
Oregon	16.2	12.6	3.7	9.2	7.2	2.1
Pennsylvania	76.5	59.3	17.3	85.2	66.0	19.2
Rhode Island	7.5	5.9	1.5	10.5	8.3	2.2
South Carolina	21.9	17.4	4.5	10.4	8.2	2.1
South Dakota	3.6	2.9	0.7	2.7	2.1	0.6
Tennessee	40.1	31.2	9.0	18.0	14.0	4.0
Texas	99.7	78.4	21.3	38.6	30.3	8.2
Utah	10.0	7.8	2.2	3.2	2.5	0.7
Vermont	2.9	2.3	0.6	3.0	2.4	0.6
Virginia	24.7	19.2	5.5	15.7	12.2	3.5
Washington	33.0	25.7	7.3	11.2	8.7	2.5
West Virginia	7.9	6.2	1.8	8.9	6.9	2.0
Wisconsin	27.9	21.3	6.6	14.6	11.1	3.4
Wyoming	2.7	2.2	0.5	1.6	1.4	0.3
Regional Totals[2]						
New England	79.4	61.8	17.6	80.8	63.3	17.6
Middle Atlantic	380.1	297.0	83.1	293.4	229.3	64.2
East North Central	248.0	192.9	55.1	147.9	114.9	33.0
West North Central	90.1	70.5	19.6	54.6	42.8	11.8
South Atlantic	226.0	176.0	50.0	125.0	97.3	27.7
East South Central	90.5	70.6	19.9	63.4	49.6	13.8
West South Central	154.3	121.4	32.9	72.0	56.5	15.4
Mountain	48.5	38.0	10.5	16.1	12.7	3.4
Pacific	243.4	189.3	54.1	115.8	90.0	25.8

1. The data available for Arizona are not sufficient to split out spending on individual services.

2. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MI, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

Conclusions

We estimate that the House Budget Committee proposal would have very significant effects on the current Medicaid program. There would be a reduction in federal spending of $932 billion over the 2013 to 2022 period because of the repeal of the Affordable Care Act and another $810 billion due to the block grant. Together, these cuts represent 38% total reduction in federal spending relative to the baseline spending assuming full implementation of the ACA. By 2022, total reductions total 47%.

The repeal of the ACA could reduce enrollment by 17 million. Since states have already achieved success in containing the growth of health care costs per enrollee within Medicaid, it would be difficult to lower federal payments through a block grant to states without causing reductions in enrollment. States would have to reduce spending per enrollee by 33% by 2022 to avoid enrollment cuts. If states maintain current spending per enrollee growth rates, which reflect an array of current cost containment proposal that have generally held Medicaid spending growth in check, states would have to reduce enrollment by 20.5 million. If states were able to limit per enrollee spending to rate of growth in GDP per capita, spending growth rates rarely achieved by other payers, states would still have to reduce enrollment by 14.3 million. Given their low incomes, most of those losing coverage would likely become uninsured.

States could avoid some of the enrollment cuts by increasing spending from their own resources but to completely avoid enrollment cuts would mean very large increases in spending. Overall, increases in spending would be 77% with no efficiency gains and 46% if Medicaid spending per enrollee was held to the rate of growth in GDP per capita.

We estimate the reductions in payments to hospitals and nursing homes. Assuming that states made cuts across the board, either through eligibility reductions, benefit cuts, or reimbursement rate reductions, payments to hospitals could fall by $363.8 billion and payments to nursing homes by $220.2 billion over the 2013 to 2022 period, a 22% reduction. The impact of the block grant becomes increasingly steep over time; by 2022, payments to providers would fall by 32% relative to the baseline.

Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly and individuals with disabilities, financing long-term care services and supporting safety net providers. The House Budget Plan represents a fundamental change in the structure and financing of the Medicaid program from a program with an entitlement to coverage for individuals and a guarantee to states for federal matching dollars without a pre-set limit to a block grant. In addition, under current law, the program is set to be the foundation of coverage for low-income individuals under the ACA which would be repealed under the plan. The proposed changes and reductions in federal financing for Medicaid under the House Budget Plan would almost certainly worsen the problem of the uninsured and strain the nation's safety net. Medicaid's ability to continue these many roles in the health care system would be significantly compromised under this proposal, with no obvious alternative to take its place.

[1] Paul Ryan, "The Path to Prosperity," House Budget Committee, March 20, 2012.
[2]The Hill, "House passes Republican budget for FY 2011 in 235-189 vote," http://thehill.com/blogs/floor-action/house/145259-house-passes-republican-budget-for-fy-2011-in-x-y-vote
[3] The Hill, "Rep. Paul Ryan's budget passed by the House with 10 Republican defections," http://thehill.com/blogs/floor-action/house/219093-paul-ryan-budget-passes-house-with-ten-republican-defections
[4] See: http://www.mittromney.com/issues/spending.
[5] CBO. "Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline" http://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf
[6] John Holahan and Stacey McMorrow, "Medicare, Medicaid and the Deficit Debate," Washington, DC: The Urban Institute, April 2012.
[7] Ibid.
[8] Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," March 2012; Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," April 5, 2011.
[9] Medicaid Spending and Enrollment Data from CBO's March 2012 Baseline.
[10] Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012.
[11] CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision" http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf
[12] Authors' calculation from the CBO data described above
[13] Hadley J and Holahan J. "Is Health Care Spending Higher under Medicaid or Private Insurance?" Inquiry, 40(4):323-42, Winter 2003/2004.
[14] Ibid.
[15] KFF. "Medicaid Income Eligibility Limits for Adults as a Percent of Federal Poverty Level, July 2012," http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4
[16] Authors' calculation from the Medicaid Statistical Information System; our hospital spending results include an estimate of the amount of hospital spending included in managed care capitation payments.
[17] KFF. "Medicaid and Long Term Care Services and Supports". http://www.kff.org/medicaid/upload/2186_06.pdf

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