NEED TO KNOW

AMERICANS FOR PROSPERITY FOUNDATION

MEDICAID FUNDING & BLOCK GRANTS

WHAT IS MEDICAID?

Created in 1965 as a health insurance program for low-income, low-resource individuals, Medicaid is a program run jointly between states and the Federal government providing coverage to 65 million individuals. Medicaid has expanded greatly since 1965 and current spending within the program is unsustainable. Reforms are desperately needed to control the burden Medicaid has become on the states. Medicaid spending cost over $490 billion in 2014 and represents $1 out of every $6 spent on health care in the U.S.

HOW IS MEDICAID CURRENTLY OPERATED?

Medicaid Financing is split between the states and the federal government based on a preset formula (the Federal Medical Assistance Percentages, or FMAP). Federal spending dominates the current FMAP formulas. Each state is reimbursed by the federal government for as much as 73 cents of every dollar they spend on Medicaid, with the average state receiving 59 cents per dollar (2). The ACA has expanded FMAP funding and now gives extra contributions for new enrollees (100% matching rate for new enrollees) or special circumstances (9). This consumes 20% of state budgets on average. At first glance, states seem to benefit since the federal government pays the majority of Medicaid's cost. However, in practice states are beholden to the federal government. For example, if a state wants to control Medicaid spending by eliminating waste and abuse, the hefty federal matching funds present a strong barrier. To reduce spending by a dollar, a state must find at least two dollars in savings: one to reduce the state's own spending and one for the federal government matching contribution that is lost as a result. This arrangement provides a powerful disincentive to reform the program and encourages states to overspend.

State officials are further handicapped by a slew of strings attached to the federal funding – federal restrictions and regulations that limit states' flexibility, innovation, and ability to tailor the Medicaid program to the needs of their state. One example is the current federal "Maintenance of Effort" (MOE requirement put in place by the so-called stimulus bill in 2009 and extended under the President's new health care law. MOE dictates that states cannot cut Medicaid eligibility below what it was prior to the recession, and states that fail to comply will lose all their federal matching funds. As a result, states looking to reduce budget deficits with spending cuts find Medicaid (which consumes 24 percent of state budgets on average) completely off limits (3). As the Medicaid expansion continues, more and more Americans will be added to the rolls, putting further strain on state budgets (4).

HOW CAN POLICYMAKERS REDUCE THE COST OF MEDICAID WHILE IMPROVING SERVICES?

The most efficient way to control the dramatic growth of Medicaid spending is by converting the federal funds into a block grant. Block grants would provide states with a fixed sim of money to operate the program. If a state spends more than the block grant, it must come up with the extra money. Similarly, if the state spends less, it is able to keep the savings. With a block grant, states are able to match the unique needs and priorities of their residents by choosing what services to provide and who to cover without fear of losing federal dollars. States are likewise granted the flexibility needed to find innovative ways to improve services and control costs.

QUICK FACTS

- Medicaid cost over $490 billion in 2014, consuming 19.3% of all state spending (1).
- Medicaid spending is projected to double by 2024, and by 2021, one in four Americans will be on Medicaid.

NOTABLE & QUOTABLE

"We're tired of having to come up to Washington to beg for waivers or even state plan amendments. We want flexibility. For myself, I would take a capped block grant in return for true flexibility to run the program in the best way."

- **Haley Barbour**, Governor of Mississippi

The good news is that block grants have already been tried with great success. In 1996 a Republican Congress and President Bill Clinton transformed the Aid to Families with Dependent Children (AFDC) welfare program into a block grant program. With finite funding, state were given an incentive to reform programs to improve effectiveness and reduce costs. Critics argued that costs were being shifted from the federal government to the states and a "race to the bottom" would occur. Instead, the new program, Temporary Assistance for Needy Families (TANF), has been a remarkable success. Welfare rolls decreased by 60 percent, and by total federal spending on TANF decreased, when adjusted for inflation, from 1997 to 2012 (5). Savings were found by streamlining program administration and targeting the program to the truly needy. Given the right incentives and freedom to propose changes, states saved money while better serving the poor.

In January 2009, Rhode Island received a special waiver that converted their federal Medicaid funds into a block grant for five years. With flexibility to use the funds as they saw fit, state officials were able to save over $100 million within the first year (6). Washington State and Texas, recognizing the value of block grants and limited federal interference, passed laws in 2011 and 2012, respectively, requesting a block grant waiver from the Department of Health and Human Services. These waivers are yet to be granted.

CONCLUSION

Medicaid's rapid spending growth over the last decade is projected to continue, with the program costing a projected $853 billion in 2022 (7). With the addition of millions of individuals into Medicaid under the President's health care law, states need flexibility to control their Medicaid budgets. Ending onerous MOE requirements and converting funding into block grants to encourage innovation at the state level are strong steps in the right direction.

Endnotes:
1. National Association of state budget officers
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4. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL (May 2010) (online at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf).
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7. Texas Senate, Letter to Lieutenant Governor Dewhurst and Speaker Straus (November 15, 2012) (online at http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/c885.
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9. CBO https://www.fas.org/sgp/crs/misc/R43847.pdf

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