

# A Medicaid Block Grant Program: Implications for People with Disabilities



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# Introduction

The rapidly growing federal deficit has intensified calls for federal entitlement reforms. A wide variety of proposals to reduce the federal deficit have been advanced in recent years, many of them centered around efforts to control future spending on Social Security, Medicare, Medicaid, and other entitlement programs. One of the most controversial of these proposals involves capping federal Medicaid payments to the states and converting the existing program into a block grant authority.

The aim of this paper is to examine the history of federal block grant programs in general and, more specifically, proposals to block grant federal Medicaid funding. The paper also summarizes findings from studies examining the potential impact of current and past Medicaid block grant proposals, and explains the broader fiscal challenges that have led federal policymakers to consider capping federal Medicaid funding and converting the program into a block grant authority.

Medicaid plays a critical safety net role in financing health care services in the United States, but the future of the program is shrouded in uncertainty because of the nation's heavy—and growing—debt burden. Approximately one out of five Americans relies on Medicaid for health care coverage, and under current law some 18 million additional people will begin receiving benefits in 2014 when eligibility is extended to virtually all adults with incomes under 138 percent of the federal poverty level (FPL).<sup>1</sup> People with substantial disabilities are especially reliant on Medicaid for health care and long-term supports provided in both institutional and home and community-based settings. The 9.8 million people who qualified for Medicaid benefits in 2010 on the basis of disability accounted for 45 percent of all nonelderly children and adults with substantial disabilities in the nation.<sup>2</sup>

Proponents of block grants argue that they reduce administrative costs by creating a single, streamlined set of federal requirements, thus eliminating confusing and sometimes contradictory administrative rules associated with the categorical grant

programs they replace. In addition, they offer state and local jurisdictions greater flexibility in using federal dollars to pursue their own program priorities. Also, when programs previously administered by several cabinet-level agencies are consolidated, proponents contend that the need for interagency coordination is greatly reduced.

Recognizing the vulnerability of people with disabilities to major structural changes in Medicaid policy, in the fall of 2011 the National Council on Disability (NCD) commissioned a study of the potential impact of converting the current Medicaid program into a state block grant authority. This report is intended to clarify the effects of shifting from open-ended, entitlement-based Medicaid funding to a block grant format under which states would receive a fixed amount of federal assistance each year. Specifically, the report—

- Examines the underlying rationale for block granting federal Medicaid funding, including the factors fueling current interest in limiting the Federal Government's role in financing health care and long-term supports for vulnerable, low-income Americans;
- Discusses the key policy choices involved in designing a Medicaid block grant authority;
- Reviews available estimates of the likely impact of a cap on federal Medicaid financial participation, combined with statutory provisions allowing states to exercise greater latitude in determining eligibility, benefits, and other key operational parameters of their Medicaid programs; and
- Analyzes the potential effects of alternative approaches to controlling the growth in federal-state outlays for medical assistance services.

# CHAPTER 1. **The Fiscal Cliff and Future Federal Medicaid Funding**

Federal deficit spending reached \$1.1 trillion in fiscal year (FY) 2012, marking the fourth year in a row that the deficit has topped a trillion dollars.<sup>3</sup> Total U.S. government debt grew from \$5.7 trillion in January 2001 to \$16.1 trillion in September 2012.<sup>4</sup> The Congressional Budget Office (CBO), the nonpartisan arbitrator of Congressional fiscal and economic projections, has reported that the federal debt held by the public exceeded 70 percent of the gross domestic product (GDP) on September 30, 2012—the highest level since 1950 and 75 percent higher than the debt-to-GDP percentage in 2008 when the current, prolonged national recession began.<sup>5</sup>

## **Contributing Factors**

By far the most prominent factors contributing to continued deficit spending are the structural imbalances in the three largest federal entitlement programs: Social Security, Medicare, and Medicaid. The growing fiscal pressure exerted by these programs can be traced to two interrelated factors: demographics and escalating health care costs. Over the next quarter century, the percentage of the U.S. population over 65 years of age is expected to grow from 13 percent to 20 percent, while the percentage of the population between 20 and 64 years of age declines from 60 percent to 55 percent. As a result of these demographic shifts, the number of active workers per Social Security beneficiary is expected to drop from 3 to 1 to 2 to 1 by 2037.<sup>6</sup>

As a growing number of senior citizens enroll in Medicare and Medicaid, demand for increasingly expensive health care services is expected to rise sharply, with federal health care expenditures growing from slightly more than 5 percent of GDP today to 10 percent by 2037. Spending on Social Security benefits is expected to increase at a much slower pace, rising from 5 percent of GDP today to 6 percent of GDP in 2020 and

subsequent decades. When the effects of an aging population and rising health care costs are combined, CBO predicts that federal health and Social Security costs will increase from 10 percent to 16 percent of GDP over the next 25 years. Five percentage points of GDP may not sound like much, but they represent more than the nation spent on national defense (4.7% of GDP) in FY 2011—and also more than it spent on *all* discretionary, nondefense programs and activities (4.3% of GDP) that same year.<sup>7</sup> Viewed from a broader perspective, a five-point increase in the share of the domestic economy would translate into \$850 billion in current dollars. By comparison, *all* federal expenditures, excluding interest payments on the national debt, have averaged 18.5 percent of GDP over the past 40 years.<sup>8</sup>

## **Approaching the Fiscal Cliff**

For years, the message from economists has been clear: unless the growth in health care costs and Social Security benefits is curtailed, either federal tax revenues will have to be raised to unprecedented levels or the nation's ever-expanding debt burden will become economically unsustainable. Yet, despite the development of multiple deficit reduction plans in recent years, attempts to solve the debt crisis have stalled in Congress.

During the summer of 2011, a stopgap plan was approved that called for slightly less than \$1 billion in spending reductions over 10 years followed by another \$1.3 billion in savings to be recommended by a bipartisan Congressional panel. When this “super committee” failed to reach consensus during the fall of 2011, the legislation authorizing the cuts (the Budget Control Act of 2011) directed the President to institute automatic, across-the-board reductions in both domestic and military spending totaling \$1.3 billion over 10 years.

These “sequestration” cuts were scheduled to take effect on January 1, 2013, but Congress intervened at the last minute to avert the “fiscal cliff,” a combination of tax and spending increases that economists predicted would stymie the fragile economic

recovery and likely lead to another recession. The American Taxpayer Relief Act of 2012 made permanent lower, Bush-era tax rates on income up to \$400,000 for individuals and \$450,000 for families. The legislation also (1) permanently indexed the threshold of the Alternative Minimum Tax exemption; (2) extended emergency unemployment benefits for one year; (3) postponed a scheduled reduction in Medicare physician payment rates for an additional year; (4) delayed automatic, across-the-board spending cuts for two months; and (5) extended farm policies and programs through September 30, 2013.<sup>9</sup>

Congress, however, was unable to reach agreement on a long-term plan for reducing the deficit through spending cuts and revenue enhancements. As a result, the 112th Congress will face a new fiscal crisis by the end of February 2013 when the two-month delay in sequestration expires and legislation to raise the debt ceiling will have to be enacted to avoid defaulting on the government's outstanding obligations. Once again, the debate will focus on approaches to reducing Social Security, Medicare, and Medicaid spending as well as securing increased revenues through reforms in the tax code. The future of the federal-state Medicaid program is integrally tied to the outcome of this and subsequent battles over the proper role of the Federal Government in promoting the best interests of the American public.

## **The National Debt and Controlling Health Care Outlays**

Attempts to reduce deficit spending have been a staple of Washington politics for decades. Yet, despite repeated proposals to bring federal spending and revenues into balance, the nation's debt has continued to mushroom. The publicly held debt of the United States has increased for 55 straight years, growing from \$257 billion to over \$16 trillion.<sup>10</sup> Interest payments on the outstanding debt reached \$454.4 billion in FY 2011,<sup>11</sup> more than the government expended that year on any program area except national defense, Social Security, and Medicare benefits.

Over approximately the same period (1960–2006), aggregate health care expenditures in the United States grew by an average of 9.9 percent per year, while the GDP

increased at an average annual rate of 7.3 percent. After adjusting for inflation, the average annual gap between the growth in health care spending and the growth in GDP was 2.5 percent.<sup>12</sup> Average per capita health care expenditures increased by 72 percent between 2000 and 2010, rising from \$4,878 to \$8,402.<sup>13</sup> Per capita spending on health care services is considerably lower in other industrialized nations such as Canada (\$4,205), Germany (\$4,187), United Kingdom (\$3,253), France (\$3,835), and Italy (\$2,852), all of which, unlike the United States, offer their citizens universal access to health services.<sup>14</sup>

With 10,000 Baby Boomers retiring each day, the financial pressure on the government's two principal health programs—Medicare and Medicaid—is going to intensify over the next several decades. According to CBO projections, Medicare expenditures under current law assumptions will increase as a share of GDP from 3.7 percent in 2012 to 4.2 percent in 2022 and to 6.0 percent in 2037. Meanwhile, Medicaid expenditures will increase from 1.7 percent of GDP in 2012 to 3.0 percent of GDP in 2022 and 3.6 percent of GDP in 2037. Health outlays alone, primarily Medicare and Medicaid expenditures, make up about four-fifths of the anticipated growth in the federal deficit over the 25-year period.<sup>15</sup> Given these realities, it is clear that curbing excess growth in health care outlays must be a central component of any deficit reduction strategy.

Despite numerous attempts over the past 30 years to control costs, health expenditures have continued to rise at a rate in excess of the general economy. By tying Medicare reimbursements to standardized diagnosis-related groups (DRGs) in the 1980s and expanding the use of managed care techniques throughout the 1980s and into the 1990s, government policymakers were able to slow the rate of growth in health care expenditures. But, growth rates subsequently bounced back to historic levels.

## **The Affordable Care Act**

The 2010 health reform legislation, commonly referred to as the Affordable Care Act (ACA),<sup>16</sup> contains many provisions aimed at controlling the rise in near-term and longer-

range health care outlays. Among the short-term cost containment strategies included in the law are provisions reducing payments to Medicare providers (e.g., primarily Medicare Advantage plans and hospitals), requiring pharmaceutical firms to pay higher rebates to state Medicaid agencies, eliminating fraud and abuse in the Medicare and Medicaid programs, introducing electronic records to simplify health insurance administration, implementing value-based purchasing programs, and establishing an approval process for purchasing generic biologic agents.<sup>17</sup>

At the same time, the ACA includes numerous provisions intended to dampen the long-term growth of health outlays by improving the efficiency and cost-effectiveness of delivering health services. A new Center for Innovation has been established within the Centers for Medicare and Medicaid Services (CMS) to support and evaluate experimental health care delivery models, care coordination methods and payment reforms. Among the center initiatives already under way are (1) a Medicare Shared Savings Program where groups of health care providers, called Accountable Care Organizations, coordinate their services and are allowed to share in any cost savings; (2) projects to test methods of “bundling” payments to different providers so Medicare and Medicaid beneficiaries receive more coordinated and efficient care; (3) patient-centered Medical Homes for patients with chronic illnesses; and (4) coordinated care demonstration projects for individuals dually eligible for Medicare and Medicaid services. The ACA also mandated the establishment of (1) a private, nonprofit Patient-Centered Outcome Research Institute to develop research priorities and conduct and disseminate findings from comparative effectiveness studies of health care interventions, including their risks and benefits; and (2) an Independent Payment Advisory Board to recommend methods of eliminating excess Medicare spending and proposing ways of slowing the growth of private health expenditures while preserving or enhancing service quality.<sup>18</sup>

Although the health care reforms currently in the pipeline hold considerable promise, there is scant evidence at present that they will succeed in containing the growth in health spending on a broad scale and in diverse settings. Indeed, it will take years to fully evaluate the impact of the various payment and service delivery reforms presently

underway or planned. Federal and state policymakers in the meantime cannot afford to wait until all the evidence is accumulated and conclusions are drawn. They need to act now to curb the growth in deficit spending and thereby preserve the integrity of the nation's financial system.

Given the importance of controlling federal health care expenditures, changes in Medicaid spending policies are virtually inevitable. All of the major deficit reductions plans advanced in recent years have sought to limit Medicare and Medicaid spending, but they have done so in significantly different ways and to different extents (see Appendix B for an expanded discussion of the major deficit reductions plans and their likely impact on future federal Medicaid spending).

The question is: how will the Medicaid program be changed? Older Americans and people with disabilities would be at special risk should lawmakers choose to convert the Medicaid program into a block grant authority. At present, they constitute about one-quarter of all program beneficiaries but account for almost two-thirds of Medicaid spending because of their elevated need for health services and high reliance on Medicaid to pay for long-term services and supports.<sup>19</sup> As pointed out later in this paper, states would face strong pressures to scale back services to low-income seniors and people with disabilities if federal Medicaid funding were to be capped.

## CHAPTER 2. **Origins and Effects of Federal Block Grant Programs**

The concept of consolidating federal assistance programs with similar or overlapping statutory purposes dates back to the late 1960s. The earliest block grant programs were comparatively narrow in scope and aimed primarily at enhancing state-local flexibility. During the Reagan Administration the focus changed, and block grants became a vehicle for shrinking the role of the Federal Government and devolving responsibility for financing and administering domestic assistance programs to state and local jurisdictions.

### **History of Block Grants**

Over the past 40 years, there have been three major waves of federal block grants. The first wave occurred during the early 1970s when President Nixon proposed that 129 federal domestic assistance programs be consolidated into six block grant programs. Many of the President's proposals were rejected by Congress, but three sizeable block grant programs had been established by the late 1970s. The next major wave of block grants occurred during the first year of the Reagan Administration when Congress, at the President's request, consolidated 77 federal grant programs into nine block grant authorities. Unlike earlier block grant programs, funding for the Reagan-era block grants were significantly below the aggregate level of the categorical programs they replaced.

Finally in the mid-1990s, President Clinton signed into law a welfare reform measure repealing the Aid to Families with Dependent Children (AFDC) program and replacing it with a state block grant program called Temporary Assistance to Needy Families (TANF). Passage of this legislation marked the first and to date the only time that Congress has agreed to transform an open-ended entitlement into a state block grant authority.

Over the past 30 years, periodic attempts have been made to convert the federal-state Medicaid program into a block grant authority. The first major attempt occurred in 1981

when Congress narrowly rejected President Reagan’s proposal to block grant federal Medicaid funding. In 1995, the Republican-controlled Congress passed legislation that would have capped federal Medicaid payments to the states and transformed the program into a block grant authority, only to have the legislation vetoed by President Clinton. Congress failed to act on a Medicaid block grant plan advanced by President George W. Bush as part of his proposed FY 2004 budget. More recently, a plan to block grant federal Medicaid spending was approved by the Republican-controlled House in both 2011 and 2012 as part of broader blueprint for reducing federal spending, lowering tax rates and slicing the deficit. The U.S. Senate, however, refused to act on the House budget plan and it died at the end of the 112th Congress (see Appendix A for additional information on the history of federal block grant programs and proposals).

## **Lessons Learned from Past Block Grants**

What can we learn from examining past experience with federal block grants? First, the real value or purchasing power of block grant funding tends to decline over time after adjustments are made for inflation. In a study of five Reagan-era block grant programs, Peterson and Nightingale found that the real dollar value of four of the programs declined between 1986 and 1995.<sup>20</sup> A later study of 11 federal block grant programs concluded that the current value of federal funding fell by an average of 11 percent over the study period.<sup>21</sup> The factors leading to reductions in federal support are difficult to untangle, but one possible explanation is that the consolidation of separate program authorities disrupts the targeted advocacy that previously existed for programs rolled into the block grant. It is harder to rally Congressional support for your particular cause if you know that the ultimate decision on how funds will be used rests with state or local officials.

Second, once block grants are authorized, the degree of flexibility afforded to state and local officials tends to erode over time. In a process sometimes referred to as “creeping categorization,” Congress adds new restrictions, set-asides for particular purposes, or new categorical programs with similar or overlapping aims. As Feingold and colleagues point out, “[a] common explanation traces this phenomenon to members of Congress,

who seem to reap greater electoral benefits from narrowly targeted categorical programs or set-asides than from wide-ranging block grants.”<sup>22</sup> Illustrations of these recategorization patterns can be found in the first two block grant programs created by Congress. The Partnership for Health Act retained its original flexibility, but its impact waned when Congress, concerned about state administrative performance, created more than 20 new categorical grants for health services outside the block grant.<sup>23</sup> Dissatisfied with state administration of the Safe Streets program, Congress added mandatory set-asides and other requirements that reduced state flexibility and later terminated funding for the program.<sup>24</sup>

Third, implementation of new block grant programs tends to be smoother when states administered the categorical programs replaced by the block grant. When an administrative structure is already in place and recipient and provider relationships have been established, state officials have an easier time incorporating new responsibilities into existing management systems. Conversely, problems are more likely to arise when state governments assume responsibility for administering programs where the Federal Government previously awarded grants directly to local governmental units or nonprofit organizations. The Community Services Block Grant, created by Congress in 1981, is a case in point. Here state governments had to establish administrative structures, fill new staff positions, and develop new relations with service providers in a policy area where states previously had little or no role.<sup>25</sup>

## **Financial Impact of the TANF Block Grant**

The enactment of the TANF block grant program was an important shift in federal policy since it marked the first time an entitlement to services was replaced with a block grant authority. Block grants enacted from the 1960s through the early 1990s involved the consolidation of discretionary grant programs, with the aim of streamlining administration and enhancing state and local decision-making authority. In contrast, the statutory authority of the AFDC program created an individual right to benefits tied to state-established income eligibility standards. Similar to other entitlement programs, Title IV of

the Social Security Act committed the Federal Government to share in the cost of all benefits regardless of the sums previously appropriated for AFDC payments to the states.

The TANF program severed this link between individual eligibility, benefits, and federal financial participation. Indeed, Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) explicitly indicates that “This part [of the statute] shall not be interpreted to entitle any individual or family to assistance under any State program funded under this part.”<sup>26</sup> In most instances, adult recipients of TANF benefits are required to work at least part time to receive benefits. In addition, beneficiaries are eligible to receive assistance for a maximum of five years, although some states apply a less stringent cap.

As welfare caseloads plunged and employment rates increased during the late 1990s and early 2000s, the 1996 welfare reform legislation was widely praised by politicians of both major political parties. But the depressed economic conditions of the past four years have revealed the underside of shrinking the social safety net. The number of children receiving federal cash assistance declined between 1996 and 2011 by more than half. Children made up more than three-quarters of TANF recipients in 2009. The average cash payment to a family with one child was \$324 a month in FY 2009, but those payments were supplemented by noncash benefits (e.g., child care, employment training) in most states.<sup>27</sup> The law empowers each state to set its own cash assistance level, which vary widely from state to state (ranging from a high of \$923 a month in Alaska to a low of \$170 a month in Mississippi in FY 2009).<sup>28</sup>

Despite \$5 billion in additional federal TANF aid provided through the 2009 economic stimulus legislation,<sup>29</sup> program caseloads have risen by only 15 percent since the recession began in 2007. Welfare caseloads remain 68 percent below their 1996 peak and just one in five low-income children currently live in a family receiving TANF funds. Meanwhile, faced with sinking revenues and increased service demands, states have sliced assistance by shortening time limits, tightening eligibility rules, and reducing benefit levels. Moreover, with the removal of statutory constraints, many states have diverted TANF funds to other purposes. Arizona, for example, currently uses only about one-third of its TANF allocation for cash benefits and work programs—core purposes of

the TANF legislation. The remaining funds pay for human services, such as foster care and adoption services, or fill other holes in the state's budget. Nationally, only about 30 percent of federal TANF payments are spent on cash benefits.<sup>30</sup>

Proposals to convert the federal-state Medicaid program into a block grant authority are more akin to the AFDC-to-TANF conversion than to other existing block grant authorities.<sup>31</sup> The financial impact of the PRWORA on federal cash assistance to low-income children and families, therefore, offers important warning signals about the potential impact of converting Medicaid entitlement funding to a block grant authority.

## **Current Medicaid Block Grant Plan**

The latest version of a Medicaid block grant surfaced as part of a broader plan to reduce federal spending that was unveiled by House Budget Committee Chairman Paul Ryan in January 2010. Titled "The Roadmap to Prosperity," the Ryan plan called for deep reductions in federal entitlement and discretionary spending and lower federal taxes as part of a broad-scaled effort to reduce the deficit and stimulate the national economy.<sup>32</sup> In the spring of 2011, the U.S. House of Representatives adopted the Ryan plan for reducing the deficit as part of its FY 2012 budget resolution. Congress took no steps to implement the House-passed budget resolution, however, because of the continuing impasse between Congressional Republicans and President Obama over the most appropriate pathway to reducing the deficit.

On March 29, 2012, a somewhat modified version of Chairman Ryan's original plan—including block granting Medicaid funds—was again adopted by the House as part of its FY 2013 budget blueprint. The resolution called for slicing \$5 trillion from federal spending over a 10-year period.<sup>33</sup> The budget resolution also included instructions to six House committees to develop legislative proposals to implement the plan, including the committees with jurisdiction over Medicaid. But, given strong opposition in the Senate and threats of a Presidential veto, no action was taken on the House-passed budget plan prior to the November 2012 Presidential and Congressional elections.

## **Key Features of the House-Passed Budget Plan**

Under the provisions of the House-approved budget resolution (H. Con. Res. 112), the existing Medicaid program would be replaced by a block grant authority under which each state would receive a fixed sum of federal dollars beginning in FY 2014. In addition, the ACA<sup>34</sup> would be repealed and, consequently, the planned expansion of Medicaid benefits to individuals and families with income under 138 percent of the poverty level would not occur. Future Medicaid funding allocations would be tied to the amount of federal aid each state received in FY 2011, adjusted for inflation and population growth during the intervening years.<sup>35</sup> A state's allocation in subsequent years would be based on the amount it received during the prior year, also adjusted for inflation and population growth. In addition, states would be given expanded latitude in establishing eligibility and coverage standards for their program, with the precise dimensions of state flexibility to be spelled out during the legislative process.<sup>36,37</sup>

## **Assessment of Fiscal Impact**

Because the level of funding under the House Budget Committee's block grant plan would not keep pace with the expected growth in health care costs and the influx of new Medicaid beneficiaries—especially the anticipated growth in high-cost older recipients—federal funding would fall further and further behind actual program costs with each passing year. According to one analysis based on CBO projections, total federal Medicaid funding between 2013 and 2022 would be \$1.7 billion, or 38 percent, below the projected level under current law.<sup>38</sup> Of the total, \$932 billion would be attributed to the ACA repeal (assuming that all states otherwise would implement the planned Medicaid expansion) and \$810 billion would be due to the block grant funding cap.<sup>39</sup> Federal funding losses would vary from state to state, with states currently offering broad coverage and having lower federal matching ratios experiencing smaller reductions than states with narrower programs and higher federal matching ratios. Federal allocations to states such as Arizona, Florida, Georgia, and Texas could be sliced by 45 percent or more over the 10-year period, and nine other states could experience reductions of

40 percent or more. Even states with broad Medicaid coverage and low matching rates would experience federal aid reductions in excess of 30 percent.<sup>40</sup>

Faced with sharp reductions in federal assistance, few viable options would be available to states since they generally have held Medicaid per capita expenditures and administrative costs below those of private health insurers. Between 2000 and 2009, overall Medicaid spending increased by 4.6 percent, with acute care spending increasing by 5.6 percent per enrollee and long-term care spending increasing by 3.0 percent per enrollee. Medicaid expenditures per enrollee were slightly above the medical care consumer price index (CPI) and the GDP increase during the period, but they were considerably below the growth rate of national health expenditures as well as the growth rate of employer-sponsored health insurance premiums.<sup>41</sup>

To understand the effects of a block grant on Medicaid enrollment and benefits, researchers at the Urban Institute (UI) examined two possible approaches that a state might adopt in response to a Medicaid block grant.<sup>42</sup> In the first scenario, the team assumed that the growth in per capita spending would follow the CBO's existing projections over a 10-year period (an average annual growth rate of 5.7%, or the projected increase in GDP + 1.6%). On a nationwide basis, they concluded, Medicaid enrollment would decline by 20.5 million, or 35 percent under this scenario. When the loss of enrollment associated with an ACA repeal was included, total Medicaid enrollment would drop by 37.5 million, or by 50 percent compared with current law assumptions. Under the second scenario, the research team assumed that states would reduce the growth in per-person expenditures (thus mitigating the need for enrollment cuts) and apply these reductions proportionally across all eligibility groups to accommodate the loss of federal aid. Medicaid enrollments would decline under this scenario by 14.3 million, or 25 percent, by 2022. When the effects of ACA repeal are added, enrollment would decline by 31.3 million over the 10-year period, or by 42 percent.<sup>43</sup>

The UI research team also estimated the increase in state expenditures that would be required to avoid enrollment reductions. If per-enrollee expenditures were to increase at the current projected rate through FY 2022, the team concluded that states collectively

would have to increase their baseline share of Medicaid expenditures by \$273 billion over the 10-year period to preserve program participation and benefit levels. This would represent a 77 percent increase in the states' share of Medicaid costs by 2022. If states were able to hold per person Medicaid spending to the rate of GDP growth (instead of GDP + 1.6%), the states' share of increased program outlays would grow by \$165.2 billion over the 10-year period. This would still represent a 46 percent increase in state Medicaid outlays compared with current law projections.<sup>44</sup>

Based on its analysis, the UI research team concluded that the ACA repeal in combination with spending reductions associated with a Medicaid block grant "... would almost certainly worsen the problem of the uninsured and strain the nation's safety net. Medicaid's ability to continue [its] many roles in the health care system," they added, "would be significantly compromised under the [House block grant] proposal, with no obvious alternative to take its place."<sup>45</sup> The CBO reached similar conclusions after assessing the likely impacts of the House Budget Committee's proposal. "States would have additional flexibility to design and manage their Medicaid programs and might achieve greater efficiencies in the delivery of care than they do under current law," the CBO noted, "[but] the large projected reduction in federal payments would probably 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."<sup>46</sup>

## **Alternative to a Block Grant**

Instead of converting Medicaid into a block grant authority, some policymakers have suggested that a "per capita cap" be imposed on future federal Medicaid funding.<sup>47</sup> Under this approach, federal assistance to each participating state would be limited to a fixed dollar amount determined by multiplying a per capita allowance times the number of eligible program beneficiaries. Typically, per capita cap proposals would limit federal financial participation on a state-specific basis, taking into account historical data on the state's per beneficiary expenditures. Some proposals would establish a single, aggregate cap applicable to all program beneficiaries, while others would set separate

caps for defined groups of beneficiaries such as children, seniors, nondisabled adults, and adults with disabilities. Most propose that the cap be adjusted annually to account for inflation using the same percentage adjustment factor in all states.

Like block grants, per capita cap proposals typically include provisions aimed at granting states wider latitude in designing and operating their Medicaid programs, such as allowing them to override statutory requirements governing benefits, premiums, and cost sharing. Unlike block grant plans, per capita cap proposals may preserve some existing Medicaid eligibility requirements, including an individual entitlement to services. If so, all people who meet state and federal eligibility requirements have a right to enroll in the program, and caseloads are likely to rise during recessionary periods. On the other hand, per capita cap proposals, like block grant plans, may allow states to restrict enrollment or eliminate the eligibility of selected groups of recipients that federal law now requires them to cover.

Although a great deal depends on the design features of the particular proposal, a recent Center on Budget and Policy Priorities analysis pointed out that per capita cap proposals share many of the same limitations as block grant plans. First, the gap between the cap on federal financial participation and actual state Medicaid expenditures is likely to widen over time. The primary aim of imposing a per capita cap is to achieve significant federal savings. This objective is usually accomplished by allowing the federal per-beneficiary cap to grow at a slower pace than the anticipated growth in per capita expenditures. Consequently, a state is forced to make up the difference with its own dollars if it is unable to achieve offsetting cost reductions—a challenging proposition given Medicaid's low administrative costs and the reduction in provider payments and benefits that have occurred in many state programs over the past four years.<sup>48</sup>

Second, given present demographic trends, the proportion of older Medicaid recipients or those who have physical, psychiatric, or developmental disabilities will increase over the next two decades. Per capita expenditures on behalf of seniors and people with disabilities are at least five times higher than per capita expenditures on behalf of children and nondisabled adults.<sup>49</sup> A per capita cap based on historical expenditure data will tend to understate the real costs of serving the growing number of aging Baby

Boomers and people with disabilities. Consequently, a larger and larger share of total program costs is likely to be shifted to the states and possibly to beneficiaries in the form of higher cost-sharing requirements.<sup>50</sup>

Third, a federal per capita payment cap would not take into account unanticipated increases in program costs due to breakthrough advances in technology, the availability of new and costly medications, or unanticipated epidemics. The increased costs of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic of the 1980s and early 1990s and the spike in medication expenditures during the late 1990s and early 2000s are just two examples of how Medicaid outlays have been strongly influenced in the past by unanticipated medical costs. There no reason to believe that similar developments will not impact future program costs.<sup>51</sup>

Fourth, a uniform methodology for establishing federal per capita payment caps would disadvantage some states more than others. States with comparatively low Medicaid spending per beneficiary would receive less initial federal funding and, thus, would have to finance any subsequent improvements in their Medicaid programs out of state general revenue. Moreover, a per capita cap based on historical spending would tend to lock in harsh spending reductions states have had to resort to during the current recession, and disadvantage states that experience a higher than average growth in per-beneficiary costs since future adjustments in a state's cap would be applied uniformly across all participating states. In the past, such variations have occurred because of differences in expenditure growth rates for various health care services and utilization levels, as well as differences across states in the rate of change in the organization and delivery of health care and long-term supports.<sup>52</sup>

Finally, in all probability a per capita cap designed to produce savings would require states to bear a larger share—potentially a much larger share—of the costs of expanding Medicaid eligibility, as called for under the ACA. States, therefore, would be more likely to choose not to enroll newly eligible beneficiaries in their programs—an option afforded them under the U.S. Supreme Court's June 28, 2012, ruling in *National Federation of Independent Business v. Sebelius*.<sup>53</sup>

## CHAPTER 3. **Impact of a Medicaid Block Grant on People with Disabilities**

People with disabilities are especially vulnerable to reductions in Medicaid spending; typically, they require more health services and often long-term supports as well. Fifteen and a half million Americans with disabilities depended on Medicaid as a source of health insurance in 2009, including 6.0 million seniors and 9.5 million nonelderly people with disabilities.<sup>54</sup> Medicaid—

- Covers almost two-thirds (63.6%) of public nursing home costs and virtually all costs of intermediate care facility services to people with intellectual and developmental disabilities (ICFs/I-DDs);
- Pays 44 percent of Medicaid home and community-based service costs, thereby helping more than 3 million seniors and people with disabilities to avoid institutionalization;
- Compensates millions of home health aides, attendants and other personal care workers. Existing shortages among such workers would be greatly exacerbated by reductions in Medicaid spending, especially in the face of a projected 79 percent increase in the number of elderly citizens between 2010 and 2030;
- Offers financial protection to husbands and wives who have spouses living in nursing homes, and provides support to family members who care for loved ones at home;
- Helps many of the estimated 52 million family members who furnish informal services and supports to seniors and people with disabilities, thus allowing them to hold jobs, care for their families, and manage the physical and emotional stresses of caregiving; and

- Is a primary source of income for approximately 15,700 nursing facilities and 33,000 providers of home-based care across the nation. In addition to the millions of Americans employed in these facilities, Medicaid also saves U.S. businesses an estimated \$33 billion annually in absenteeism and lost productivity by workers with home caregiving duties.

## CHAPTER 4. Conclusion

Some federal policymakers support converting Medicaid to a block grant authority or instituting a per capita Medicaid spending cap because it would result in large budgetary savings that could be used to pursue other policy goals deemed to be of higher priority (e.g., permanently reducing federal tax rates and increased defense spending). If the federal share of Medicaid funding were capped, responsibility for making the tough calls on slicing benefits or trimming eligibility would be shifted to the states, which lack the fiscal resources to replace lost federal assistance. Instead of the Federal Government picking up half to three-quarters of the cost of future recessions, epidemics similar to the HIV/AIDS outbreak of the 1980s, and the introduction of new, high-cost pharmaceuticals and breakthrough treatments, states would be left to their own devices in coping with the financial uncertainties of the health care marketplace. Block grant funding would place states and program beneficiaries in a far more vulnerable financial position than they are today.

Older Americans and people with disabilities would be at special risk. At present, they constitute about a quarter of all program beneficiaries but account for almost two-thirds of Medicaid spending because of their elevated need for health services and high reliance on Medicaid to pay for long-term services and supports. States would face strong financial pressures to reduce services to low-income seniors and people with disabilities if federal Medicaid funding were to be capped.

Improving the overall cost-effectiveness of health care delivery systems represents a far more responsible approach to placing Medicaid outlays on a sustainable course. As noted earlier in this paper, many other industrialized nations offer universal access to health care and long-term supports at a fraction of the per person costs incurred in the United States. The ACA contains multiple initiatives aimed at improving health outcomes while lowering system-wide costs. With a renewed commitment to improved efficiency and achieving better outcomes, there is no reason why Medicaid, Medicare, and other

health care costs cannot be brought into line with the general rate of inflation. This is a better solution to the current debt crisis for all Americans, especially for older adults and people with physical, mental, sensory, and developmental disabilities.

## APPENDIX A. The History of Federal Block Grant Authorities

Medicaid block grant proposals have been the *leitmotif* of Medicaid policy for the past three decades. Indeed, the tensions inherent in operating an open-ended entitlement program have been evident from the onset of the federal-state Medicaid program. In 1967, the second year of program operations, Congress became so concerned by the rapid growth in Medicaid outlays it enacted legislation designed to curb program expenditures (P.L. 90-248).<sup>55</sup> This was the first in what was to become a recurring series of legislative and administrative efforts to rein in federal Medicaid outlays.

The earliest examples of federal block grant programs were enacted in the late 1960s when Democrats controlled both chambers of Congress and the White House. Congress created the Partnership for Health program in 1966 by combining several categorical health grants under a single program umbrella and the Safe Streets program two years later as part of the Omnibus Crime Control and Safe Streets Act of 1968.<sup>56</sup>

### Nixon-Era Block Grants

The first major, sustained wave of block grant proposals occurred in 1971, when President Nixon proposed that 129 distinct federal programs be consolidated into six block grants. A Democrat-controlled Congress rejected the President's original program consolidation plan, but nonetheless by the end of the Ford Administration Congress had enacted three sizable block grant programs. In each instance, spending under the block grant programs of the 1970s was greater than aggregate outlays under the categorical programs they replaced. Even states and cities that qualified for a smaller share of federal aid under the applicable funding formulas received more money than they had under the predecessor programs.<sup>57</sup>

### The Reagan Revolution

During the Reagan Administration, the focus changed and block grants became a vehicle for shrinking the role of the Federal Government and devolving responsibility for financing and administering domestic assistance program to state and local jurisdictions. A Medicaid block grant proposal was a major linchpin of the President's sweeping 1981 plan to shift fiscal responsibility and control back to state and local jurisdictions. Under the Medicaid portion of what came to be known as "Reaganomics," federal financial participation was to grow by 5 percent in FY 1981 and be adjusted annually thereafter by a gross national product deflator. Administration budget officials calculated that the cap would save the Federal Government \$1.1 billion in FY 1982, with the amount of savings growing steadily in future fiscal years. The President also proposed a number of statutory and regulatory changes designed to afford states greater flexibility in designing and managing their Medicaid programs. Included was a proposal to allow the Secretary of Health and Human Services to waive certain statutory requirements in order to permit

states to substitute home and community-based services for Medicaid recipients who otherwise would require care in a nursing home or another type of long-term care institution.<sup>58</sup>

Broad elements of the Reagan plan were approved by Congress as part of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35; OBRA-81). But, after extensive debate and several close committee votes, Congress rejected the President's plan to cap federal Medicaid spending and convert the program into a block grant authority. Instead, Congress enacted temporary reductions in state matching ratios over a three-year period, after which matching rates returned to pre-existing levels. The final Medicaid amendments of OBRA-81 also included a modified version of the home and community-based waiver authority initially proposed by the Reagan Administration (Section 2176 of P.L. 97-35, later codified as Section 1915(c) of the Social Security Act).<sup>59</sup> Though widely ignored at the time, the waiver authority was to have a far-reaching impact over the next three decades on rebalancing Medicaid expenditures on institutional versus home and community-based services.

## **Gingrich Plan**

In 1995, the Republican-controlled 104th Congress, under the leadership of House Speaker Newt Gingrich (R-GA), unveiled a Medicaid block grant proposal that deviated in several important ways from earlier plans to convert Medicaid to a block grant program. Referred to as the Medigrant program, the Speaker's plan, as subsequently modified during committee mark-up sessions, would have based the federal funding cap on a complicated formula designed to measure each state's relative needs. A state would be obligated to operate its program under an annual federal spending cap that took into account historical spending adjusted for state input costs (e.g., local wage rates), case mix (e.g., the relative acuity of need among program enrollees), and the number of poor people in the state. The actual amount of a state's funding allotment then would be reduced on a pro-rated basis to ensure that expenditures in all states remained under an annual aggregate Medicaid spending cap specified in the law. The proposal, with modifications, was approved by the House of Representatives and the Senate as part of a much larger measure aimed at balancing the federal budget.<sup>60</sup> However, President Clinton vetoed the legislation on December 6, 1995;<sup>61</sup> and, although Republican lawmakers included a modified version of the Medigrant plan in 1996 welfare reform legislation, it was dropped before the bill was sent to the White House.

President Clinton signed into law a welfare reform measure that repealed the AFDC program and replaced it with the TANF state block grant program. Passage of this legislation marked the first and to date only time that Congress has agreed to transform an open-ended entitlement into a state block grant authority.

## **Bush Plan**

In January 2003, President George W. Bush unveiled a proposal that offered states the option of accepting federal block grant funding in return for higher federal Medicaid aid in

the near term, enhanced administrative flexibility in operating their programs, and authority to reduce the state's share of program costs. As sketched out in the President's FY 2004 budget, an aggregate cap linked to annual budget targets was to be imposed on federal Medicaid and State Children's Health Insurance Program (SCHIP) spending. Relative to the Administration's Medicaid spending projections under existing law, the proposed federal "allotments," or block grants, were to be higher in FY 2004 through FY 2010 but lower in FY 2011 through FY 2013, resulting in "budget neutral" federal spending over the 10-year period.<sup>62</sup>

To qualify for federal funding under the President's plan, a state would have to spend a predetermined amount on health services each year, with the amount referred to as "maintenance of effort" (MOE). The MOE level was to equal the amount the state spent in FY 2002, adjusted annually thereafter by the rate of increase in medical costs. One analysis of the impact of the plan estimated that spending by states accepting the block grant option would be hundreds of billions of dollars less over the 10-year period than it would be under existing law.<sup>63</sup> States choosing the option also would have been subject to fewer federal rules governing optional services and population coverage.

Instead of fleshing out the specifics of its block grant plan, the Bush Administration asked the National Governors' Association (NGA) to hammer out the details. The NGA created a bipartisan task force charged with producing a consensus plan. But the task force disbanded in June 2003 after failing to achieve agreement. Preoccupied with legislation to add a Medicare prescription drug benefit, Congress never considered the President's Medicaid/SCHIP reform proposal. The President's FY 2005 budget stated that "the Administration remains committed to enacting legislation which will reform Medicaid and SCHIP."<sup>64</sup> Specific legislation to accomplish this objective, however, was never submitted to Congress, and the plan was quietly shelved.



## APPENDIX B. Deficit Reduction Plans and the Fiscal Cliff

The unprecedented, recession-related deficits of the past few years have solidified support across the political spectrum for adopting a long-range plan to balance the federal budget and lower the nation's debt burden. But, because of the tough political and economic decisions required to formulate a deficit reduction plan, a consensus has not yet emerged in Congress concerning the principal elements of such a plan.

### Debt Reduction Plans

In late 2009, the House approved a measure establishing a national commission to recommend steps necessary to stabilize federal expenditures and revenues over the long term. The commission's recommendations were to go into effect unless Congress adopted an alternative plan for reducing the deficit. The measure died in the Senate after proponents were unable to muster the super majority (60 votes) necessary to break a filibuster in January 2010.

In an attempt to revive efforts to forge a compromise plan, President Obama established by Executive Order a bipartisan National Commission on Fiscal Responsibility and Reform on February 2, 2010, and appointed as co-chairs of the commission former Senator Allan Simpson (R-WY) and former White House Chief of Staff Erskine Bowles.<sup>65</sup> The Simpson-Bowles commission issued its consensus findings and recommendations on December 1, 2010. The report called for reducing deficit spending by almost \$4 trillion over 18 years (by the end of FY 2020) by (1) sharply reducing tax rates, eliminating the Alternative Minimum Tax (AMT), and cutting backdoor spending through the tax code; (2) capping federal revenue at 21 percent of GDP and reducing spending to 22 percent (and eventually 21%) of GDP; (3) ensuring the long-range solvency of the Social Security trust funds; and (4) stabilizing the debt by 2014 and reducing it to 60 percent of GDP by 2023 and to 40 percent of GDP by 2035.<sup>66</sup> Eleven of the 18 members of the commission voted to approve the plan, but because the vote fell three votes short of the required three-quarters majority, Congress was not required to approve the commission's plan or adopt an alternative plan of its own with at an equal amount of deficit reduction over the 18-year period.

During the same general timeframe of the Simpson-Bowles commission, a number of other deficit reduction plans were unveiled, including proposals by President Obama; Congressman Paul Ryan (R-WI), chairman of the House Budget Committee; and a debt reduction task force headed by Dr. Alice Rivlin and former U.S. Senator Pete Domenici (R-NM). These plans laid out competing approaches to slicing federal spending and generating additional revenues by revising the existing tax code. As summarized in Table A, all of these plans included proposals to limit federal Medicaid spending to varying degrees and in varying ways.

**Table A. Medicaid Proposals: Major Debt Reduction Plans**

Plan	Main Medicaid Proposals	Estimated Savings
<p><b>Nat. Comm. on Fiscal Responsibility and Reform</b> (Simpson-Bowles) Dec. 1, 2010</p>	<ul style="list-style-type: none"> <li>● Reduce/eliminate state authority to levy provider taxes</li> <li>● Enroll dual eligibles in Medicaid managed care plans</li> <li>● Reduce funding for admin. costs</li> <li>● Expedite approval of Medicaid waivers</li> <li>● Set federal budget targets for Medicaid spending post-2020</li> </ul>	<p>\$58 billion FY 2012– FY 2020</p>
<p><b>President’s Framework for Shared Prosperity and Shared Responsibility</b> April 5, 2011</p>	<ul style="list-style-type: none"> <li>● Increase flexibility, efficiency, and accountability w/o converting program to a block grant</li> <li>● Replace current matching formula with a single matching ratio for Medicaid and the Children’s Health Insurance Program</li> <li>● Ask governors to propose Medicaid reforms</li> <li>● Limit state use of provider taxes as matching dollars, impose upper limit on purchase of durable equipment, and improve program integrity</li> </ul>	<p>\$100 billion over 10 years</p>
<p><b>Pathway to Prosperity</b> (Ryan’s Budget Plan) April 5, 2011</p>	<ul style="list-style-type: none"> <li>● Convert Medicaid to a block grant program in FY 2013; tie future growth to population and inflation (CPI/U)</li> <li>● Afford states greater flexibility in designing/operating their programs</li> <li>● Replace Medicare premium payments for dual eligibles with Medical Savings Plans</li> <li>● Repeal the Affordable Care Act</li> </ul>	<p>\$1.4 trillion over 10 years (\$771 billion without repeal of health reform law)</p>

Plan	Main Medicaid Proposals	Estimated Savings
<b>Nat. Debt Reduction Task Force</b> (Rivlin-Domenici) Nov. 17, 2010	<ul style="list-style-type: none"> <li>● Eliminate barriers to enrolling dual eligibles in managed care plans</li> <li>● Incentivize states to control Medicaid costs by reducing the federal aid to GDP inflator + 1% beginning in FY 2018 – possibly by redistributing responsibilities between the Federal Government and the states</li> </ul>	\$5 billion FY 2012–18 \$20 billion through 2020; \$202 billion through FY 2025; and \$3.0 trillion through 2040

**Sources:** *The Moment of Truth: Report of the National Commission on Fiscal Responsibility*, December 2010; “FACT SHEET: The President’s Framework for Shared Prosperity and Shared Responsibility,” The White House, April 13, 2011; *The Path to Prosperity: Restoring America’s Prosperity – Fiscal Year 2012 Budget Resolution*, House Budget Committee, April 5, 2011; Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Paul Ryan, Chairman, House Budget Committee, April 5, 2011; *Restoring America’s Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System*, The Debt Reduction Task Force, November 2010.

## The Fiscal Cliff

Despite multiple proposals, attempts to solve the debt crisis stalled in Congress, with Republicans staunchly committed to reducing the deficit almost exclusively through spending cuts and Democrats insisting on a mixture of spending reductions and increased taxes on wealthy Americans. The political impasse reached crisis proportions during the summer of 2011 when House Republicans refused to approve an increase in the debt ceiling until a long-range deficit reduction plan was adopted. With the Federal Government teetering on the brink of defaulting on billions of dollars in outstanding debt, President Obama and Congressional leaders reached a last-minute agreement calling for slightly under \$1 trillion in spending cuts spread over 10 years and the appointment of a bipartisan congressional panel to prepare a long-range deficit reduction plan to present to Congress. If the joint congressional committee was unable to reach consensus on a plan to reduce the deficit by an additional \$1.2 trillion over 10 years, the authorizing legislation, titled the Budget Control Act of 2011 (P.L. 112-25), directed the President to impose \$1.2 trillion in automatic, across-the-board spending cuts over a 10-year period. Initially, half of the reductions were to be applied to national security programs and half to nonsecurity (mainly domestic assistance) programs and were to go into effective on January 1, 2012.<sup>67</sup> Medicaid and Social Security expenditures were exempted from the second round of spending reductions and Medicare cuts were to be limited to 2 percent of program outlays.

This back-up plan, called “sequestration,” was intended to drive congressional Republicans and Democrats toward a compromise solution. The assumption was that both liberals and conservatives would prefer to craft a compromise deficit reduction plan instead of having across-the-board cuts indiscriminately applied to virtually all areas of the federal budget. But, as it turns out, the Joint Select Committee on Deficit Reduction (commonly referred to as the “Super Committee”) was unable to reach agreement on an alternative deficit reduction plan by the statutory deadline (November 23, 2011) and it disbanded. As a result, automatic, across-the-board spending reductions will go into effect on January 1, 2013, unless Congress enacts a substitute plan in the interim.<sup>68</sup>

In addition to sequestration, several other critical tax and spending provisions are scheduled to expire at the end of 2012. First, the Bush-era tax cuts, which were extended for two years under legislation signed into law by President Obama on December 17, 2010,<sup>69</sup> will revert to prior levels after December 31 unless Congress extends or revises applicable provisions of the tax code before then. The 2012 tax liability of virtually all individuals and corporations will increase if existing tax rates are not extended. Second, unless Congress extends AMT exemptions by the end of the year, millions of middle-income tax payers will pay higher—in some cases, significantly higher—2012 taxes.<sup>70</sup> Originally enacted in 1969 and revised in 1982, the AMT was intended to prevent millionaires from avoiding tax liability. But, because the law does not adjust AMT rates for inflation, each year Congress has had to enact a “patch” to prevent middle-income tax payers from paying higher alternative tax rates. Finally, unless Congress again delays application of the Sustainable Growth Rate (SGR) adjustment factor, Medicare payments to physicians will be reduced by 27.4 percent effective January 1, 2013. The SGR is an alternative method of calculating physician fees that was adopted as part of the Balanced Budget Act of 1997. CMS is required by law to calculate the annual adjustment factor, but for the past 15 years, Congress has postponed the effective date of the SGR formula.<sup>71</sup>

The combined impact of sequestration, expiration of the Bush tax cuts, and the deadline for AMT and SGR legislative fixes has come to be known in Washington as “the fiscal cliff.” Unless Congress and the White House take actions to avert the fiscal cliff, CBO predicts that the nation will experience another recession, with GDP declining by 1.3 percent during the first half of 2013.<sup>72</sup>

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67. Under revised assumptions adopted later, the sequestration would result in a 9.4 percent reduction in nondefense discretionary funding and an 8.2 percent reduction in nonexempt, nondefense discretionary funding. The sequester also would impose cuts of 2 percent cut in Medicare spending; 7.6 percent in other nonexempt, nondefense mandatory programs; and 10 percent in nonexempt, defense mandatory programs (OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155)).

68. On September 14, 2012, the Office of Management and Budget issued a report providing a detailed, program-by-program breakdown of how the spending reductions will be applied (OMB report, *Ibid.*).

69. The Tax Relief, Unemployment Compensation Reauthorization and Job Creation Act of 2010 (P.L. 111-312).

70. "Alternative Minimum Tax, Tax Guide to Investors," Fairmont.com (<http://www.fairmark.com/amt/amt101.htm>).

71. KFF, "FAQ: The 'Doc Fix'" (February 17, 2012) <http://www.kaiserhealthnews.org/stories/2011/december/15/faq-doc-fix.aspx>.

72. CBO, "Economic Effects of Reducing the Fiscal Restraint That Is Scheduled to Occur in 2013" (May 22, 2012), <http://www.cbo.gov/publication/43262>.







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