Medicaid, the Budget, and Deficit Reduction: The Threat Continues

From Families USA • August 2011

We averted default on the national debt when, in exchange for an increase in the debt ceiling, Congress passed, and the President signed, the Budget Control Act of 2011. The law includes nearly $1 trillion in spending cuts over the next decade, including cuts to vital programs. Medicaid was spared in those initial cuts; however, the Medicaid program is still at risk.

The new law establishes a "super committee" of 12 members of Congress—six Democrats and six Republicans. This committee is supposed to come up with a specific plan by the end of November—a package of policy and funding changes that would reduce the deficit by another $1.5 trillion over the next 10 years. The committee can consider anything that would reduce the deficit: cutting or totally restructuring Medicaid, Medicare, or Social Security, or raising revenue. If the committee can't come up with a plan that can be approved by the House and the Senate and signed by the President, automatic spending cuts ensue. These cuts must total $1.2 trillion over 10 years, and 50 percent will come from defense and 50 percent from other programs.[1] Medicaid is exempt from these automatic cuts, as are Social Security and most of Medicare. But automatic cuts would hit defense hard and would devastate other programs, so there is a strong incentive for the committee to come up with a plan and for Congress to pass that plan.

As the committee searches for places to find $1.5 trillion in deficit reduction, committee members are going to take a long, hard look at Medicaid. Because Medicaid will be such a tempting target for cuts, advocates will need to make the strongest possible case for the need to protect the program. Our messages are much the same as they've been since this fight began. These messages helped protect Medicaid from initial cuts and from potential automatic cuts in the debt ceiling deal. It's important to keep driving them home.

The Bottom Line: Our Message on Medicaid and the Super Committee Process

- We agree that it's important to bring down the deficit.
- But the approach must be fair and balanced, with both spending cuts and revenue increases. The super committee *must* include revenues as at least 50 percent of the savings in their plan.[2]
- And, whatever we do, we must not decimate crucial programs that seniors and their families, people with disabilities, children, and our most vulnerable citizens depend on.
- Medicaid is an efficient program, with little fat, and it should not be cut.

See next page for more of The Bottom Line.

- Medicaid is an invaluable tool when economic crises or natural disasters hit, with its ability to expand to take care of additional people when needed. We shouldn't change the structure of Medicaid.
- Simply cutting federal Medicaid funding is penny-wise and pound foolish. Less money to cover people means more visits to emergency rooms, sicker people, and overall higher health care costs, not savings.
- The way to bring down Medicaid spending is by controlling health care costs. To do that, we must keep the Affordable Care Act intact. The super committee must protect all the ways the Affordable Care Act helps people afford health coverage.

Where We Are

What's in the Law

The new Budget Control Act gives the President the authority to increase the debt ceiling in increments that should add up to enough to avoid a default on U.S. obligations through the end of 2012. It includes nearly $1 trillion in spending cuts over the next 10 years affecting defense and non-defense spending programs. The cuts would be phased in. **Medicaid, Medicare, and Social Security are exempt from those initial cuts**. It also sets up the following process for further deficit reduction:

- In mid-August, Congress will appoint 12 members to the Joint Select Committee on Deficit Reduction, the so-called "super committee." There will be six Democrats and six Republicans, three of each from the House and three of each from the Senate. This committee is charged with writing legislation that will reduce the deficit by an additional $1.5 trillion over the next 10 years.
- Each committee in Congress can submit recommendations to the super committee. Those recommendations must be submitted by October 14, 2011.
- By November 23, the super committee will vote on its recommendations and proposed legislative language. A majority vote is required for approval.
- By December 2, the super committee must submit its report and proposed legislation to Congress and the President. The committee's bill, which cannot be amended or filibustered, must be approved by Congress. Both the House and Senate must vote on the committee's legislation by December 23, 2011. The President has veto authority.
- If the super committee does not come up with proposed legislation, or if its bill is not signed into law, a process for automatic spending cuts totaling $1.2 trillion over the next 10 years will be triggered. However, if the super committee comes up with proposed legislation that reduces the deficit by an amount *less* than $1.2 trillion, the committee can still submit that to Congress. If that legislation passes, automatic cuts will be triggered to make up the difference between the deficit reduction in the super committee's bill and the $1.2 trillion target. Under the automatic trigger, the following would happen:

- Defense programs would be cut by $55 billion each year from 2013 to 2021.
- Non-defense programs would be cut by the same amount. Those cuts would come from discretionary programs and mandatory programs (i.e., entitlements—programs in which anyone who meets program qualifying criteria is entitled to participate).
- Programs that would be **exempt** from these automatic cuts include Medicaid, CHIP, Social Security, SSI, most of Medicare, veterans' benefits, some other means-tested programs, federal retirement, and tax credits. That includes the premium tax credits in the Affordable Care Act; however, the Affordable Care Act's subsidies to help people defray health insurance cost-sharing would be subject to automatic cuts. Medicare payments to providers and insurance plans would also be subject to automatic cuts, with those cuts capped at 2 percent of payments in any year.

The law also requires both the House and the Senate to vote on a constitutional amendment to balance the budget sometime between September 30 and December 31, 2011. Regardless of what happens with that vote, Congress will still need to follow the process to come up with at least $1.2 trillion in deficit reduction.

What the Super Committee Might Look at

The super committee has unprecedented authority. It has the power to dictate actual legislation and policies that will achieve the savings. And it can look at **anything**, including cutting programs that are exempt from automatic cuts, like Medicaid, and raising revenue. The super committee will be writing legislation, so its recommendations will be specific, and they can be sweeping. For example, the committee can recommend completely restructuring critical programs like Medicaid and Medicare.

We don't know what it will propose regarding Medicaid, but what's been put on the table already this year gives a good idea of the types of cuts and restructuring that might be considered. That includes deep federal spending cuts like those in the House Republican budget proposal, converting Medicaid into a block grant, caps on federal spending that would necessitate severe cuts to Medicaid, and a blended federal Medicaid matching rate. Families USA's piece *Medicaid, the Budget, and Deficit Reduction: Keeping Score of the Threats,* available online at http://familiesusa2.org/assets/pdfs/Threats-to-Medicaid.pdf, outlines what those types of proposals would mean for Medicaid and the people who rely on it.

As the process moves forward, super committee members are named, and congressional committees submit their recommendations to the super committee, we will have a better idea of the specific threats to Medicaid. But one thing is assured: Severe cuts to Medicaid will be debated as part of the process.

Evaluating Proposals

As proposals begin to take shape, there are a few questions you should ask as you look at each idea on the table.

1. Does the proposal get to the deficit reduction target solely by reducing federal spending?

If yes, it isn't a balanced approach. Such a proposal will, of necessity, need to include deep cuts in the larger health care programs, including Medicaid.

- There are two ways to reduce the deficit: cutting spending and raising revenue. Raising revenue can include increasing tax rates, imposing new taxes, or eliminating tax loopholes or deductions. A refusal to include any revenues as part of deficit reduction is a prescription for unnecessarily deep cuts in critical programs. That's true regardless of how program cuts are structured. Unless both spending and revenue are part of the equation, it is unlikely that Medicaid will be exempted from devastating cuts.

2. Does the proposal make deep cuts in Medicaid?

If yes, then Medicaid would likely be turned into a block grant.

- Even if a proposal does not explicitly convert Medicaid into a block grant, if it includes deep Medicaid cuts, Medicaid would almost certainly be converted into a block grant program. That is because the only way to ensure that federal Medicaid spending could predictably meet a radically lower spending level would be to restructure the program and convert it to a block grant. Because Medicaid is an entitlement program—meaning that anyone who qualifies is entitled to benefits—under its current structure, it is impossible to guarantee that spending will stay within a specified limit. If unemployment goes up and more people become eligible for Medicaid, for example, Medicaid spending has to go up. The only way to make Medicaid costs predictable is to change the structure of the program from an entitlement to a block grant. With a block grant, once the funding limit is reached, states can simply say, "Tough luck" to low-income people who seek health care or long-term care.

  Block grants are generally touted as a way to save money, but in fact, they save only federal money. Because most federal block grant allocations do not keep pace with inflation in health care costs, even a block grant that seems sufficient in the first year will soon fall far short of needs. States will be left holding the bag and will have to either come up with additional funding or cut people or benefits—or both. What's more, giving states carte blanche to decide who is covered and what benefits they get will likely leave our most vulnerable citizens at the mercy of state politics.

3. Even if the proposal doesn't seem to cut Medicaid, does it have across-the-board caps, cuts, or targets?

If yes, then Medicaid will certainly face deep cuts.

- The population is aging, and with that, spending on health care, including Medicaid as the major payer for long-term care, will rise. Proposals that reach the deficit reduction target by capping all federal spending, capping health care spending, or severely cutting spending will force deep cuts in Medicaid. Medicaid and CHIP make up approximately 8 percent of federal spending.[3] Proposals that require significant cuts in federal spending most likely cannot meet their goal without steep cuts to Medicaid—cuts so dramatic that the program would need to be converted into a block grant to provide the government with cost predictability. A deficit reduction approach based on radical federal spending cuts to meet the target does not deal with the costs of health care, it simply passes those costs down to states and consumers.

Messages for Decision Makers

Deficit reduction will remain a top priority for members of Congress through the end of the year. Certainly, it will be an all encompassing issue for members of Congress appointed to the super committee. But even members of Congress who are not on that committee will be thinking about the vote that they will have to take in December on the committee's recommendations. Even though there isn't yet a particular proposal to talk about, it is important that you let your members know your position, now and often, until the vote in December.

- Acknowledge that it is important to reduce the federal deficit over the long term, and that doing so requires bringing down health care costs for everyone, not just federal spending for Medicare and Medicaid.
- Emphasize that the approach to deficit reduction must be fair and sustainable; must balance spending reductions with revenue-raising measures; and must not decimate programs that seniors and their families, people with disabilities, children, and our most vulnerable citizens depend on.
- Medicaid is an efficient program, with little fat. It should be spared from cuts.[4]
- Controlling health care spending should be part of a thoughtful deficit reduction process that focuses on better care delivery, not just making arbitrary federal spending cuts and passing costs on to states and consumers. The Affordable Care Act sets a framework for making lasting improvements in health care delivery. The super committee must keep the Affordable Care Act in place and fully funded.

Looking Ahead

We'll have to work really hard over the next few months to protect the Medicaid program for those who depend on it. Unfortunately, even if we're successful, this will not be the end of the fight. Sometime near the beginning of January 2013, Congress will face another vote to extend the debt ceiling. That will provide another opportunity for those in Congress who want draconian cuts in federal spending to use the debt ceiling vote to demand those huge cuts. On the other hand, President Bush's tax cuts will expire at the end of 2012, and this may provide leverage for those who want to see a balanced approach to deficit reduction that includes new revenues, particularly from closing loopholes and raising taxes for wealthy individuals and corporations.

What happens this round, between now and December, will set the tone for what happens in 2013, when the next debt ceiling debate surfaces. That's why it is critical that we make it clear now that (1) revenues have to be substantial part—at least half—of any deficit reduction that comes out of this super committee process and (2) Medicaid should not be cut: Deficit reduction should not be done on the backs of our most vulnerable citizens or by taking away the health care safety net that any one of us, or our family members, might need.

Deficit reduction is important, and we can reduce the deficit without sacrificing the health care security of millions of Americans. Let your members of Congress know that you want to see a balanced approach that couples spending reductions with revenue increases, one that takes the long view of controlling health care costs rather than passing these costs on to families, and that anything less is unacceptable.

Endnotes

[1] The difference between the $1.5 trillion super committee target and the $1.2 trillion in automatic cuts has to do with the handling of the debt ceiling increase in the Budget Control Act of 2011. That law contained a total debt ceiling increase of between $2.1 and $2.4 trillion, to be achieved in two installments. There is an initial increase of $900 billion (part now and the remainder in September) that is specified in the Budget Control Act. Whether the second increase is $1.2 or $1.5 trillion, or somewhere in between, will depend on the super committee. If the super committee arrives at a plan with $1.2 trillion in deficit reduction, the debt ceiling will increase by that amount. If the super committee arrives at a plan that reduces the deficit by more than $1.2 trillion, then the debt ceiling will increase by that amount, up to a maximum of $1.5 trillion. If the super committee fails to come up with a plan, the debt ceiling will increase by $1.2 trillion, the amount of the automatic cuts that would be triggered.

[2] There is a rationale for demanding that the super committee's deficit reduction proposalbe made up of 50 percent spending cuts, 50 percent revenue increases. Such a 1:1 ratio of spending cuts to revenue increases—when added to the cuts already in place—would give the law's total package a roughly 2:1 split between cuts and revenues. A 2:1 ratio of cuts to revenues was what President Obama proposed in his April deficit reduction framework, it mirrors the Bowles-Simpson plan that came out of the President's Fiscal Commission, and it is the ratio contained in the proposal developed by the Senate's so-called "Gang of Six" this July.

[3] Center on Budget and Policy Priorities, *Policy Basics: Where Do Our Federal Tax Dollars Go?* (Washington: Center on Budget and Policy Priorities, updated April 2011), available online at http://www.cbpp.org/files/4-14-08tax.pdf. Medicare, Medicaid, and CHIP combined accounted for 21 percent of $3.5 trillion in federal spending in 2010. Medicare, Medicaid, and CHIP combined accounted for $732 billion, with Medicare making up $452 billion of that amount and Medicaid and CHIP the remainder, or $280 billion—approximately 8 percent of the total. (Families USA calculation.)

[4] John Holahan et al., *House Republican Budget Plan: State by State Impact of Changes in Medicaid Financing* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2011), available online at http://www.kff.org/medicaid/upload/8185.pdf. Rates of per-capita spending increases in Medicaid have been far below those of other payers. From 2000 to 2009, Medicaid per-enrollee spending was slightly above the increase in the Medical Care consumer price index, but well below growth rates in national health expenditures, both overall and per capita, and employer-sponsored premiums.

Part of a series on Medicaid,
the budget, and deficit reduction.

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