Medicaid Funding Caps Would Harm Older Americans

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Table of Contents

Executive Summary

Current "Cap" Proposals

Recent months have seen increased discussion of proposals to remake Medicaid and cap federal Medicaid payments to states. Under these proposals, the federal government would provide either block grants or per capita payments to states, and states would have broad discretion to set their own Medicaid standards. All of these proposals are designed to save federal money, and would impose rigid limits on the amount of federal money available to states. For example, the Fiscal Year 2017 House Budget proposal included capped Medicaid funding and a $1 trillion cut to Medicaid over 10 years.[1] By 2026, Medicaid funding would decrease by 33% from what is required under current law.[2] This level of budget cutting, whether imposed through a block grant or a per capita cap system, would necessitate an equally significant diminution in health care availability and quality. States would be forced to either cut current services to the bone, or devise their own shrunken Medicaid standards, without regard to medical necessity and the many existing Medicaid rules that protect beneficiaries.

1 Committee on the Budget of the U.S. House of Representatives (Chairman Tom Price, M.D.), A Balanced Budget for a Stronger America: Fiscal Year 2017 Budget Resolution, at 48-49.

2 Edwin Park, Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured, at 2 (Center on Budget and Policy Priorities 2016), available at cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave.

Medicaid Today

The Medicaid program provides for medically necessary health care that low-income older Americans otherwise cannot afford. Over six million older Americans rely on Medicaid every year.[3] Medicaid coverage is particularly important for older persons who need services not covered—or not adequately covered—by Medicare. As a result, Medicaid is vital for older persons who can no longer live independently. The long-term assistance that they need, whether provided at home or in a nursing home, can be covered by Medicaid but not by Medicare.

Medicaid programs combine federal and state funding. Federal Medicaid law sets certain basic standards, with states having discretion to add additional services or eligibility categories. In addition, federal law authorizes further flexibility for state innovation and experimentation. Such flexibility is often granted through waivers—for example, through home and community-based services (HCBS) waivers or demonstration waivers. The current level of flexibility enables states to innovate without losing federal funds or decreasing consumer protections.

How "Cap" Proposals Would Harm Low-Income Older Americans

Proposals to cap Medicaid funding to states, either through block grants or per capita caps, place health care for low-income older Americans at risk. Federal payment for Medicaid would drop sharply, resulting in fewer services for everyone who relies on Medicaid, including older adults, who account for over 22% of all Medicaid spending.[4] Simultaneously, numerous federal protections would evaporate, because states would receive federal monies with relatively few requirements. Older Americans would be harmed by lost eligibility and services, unaffordable financial obligations, and a lessened quality of care.

1. Loss of Eligibility and Services

- If implemented, the "cap" proposals would decimate Medicaid's current guarantee of adequate and affordable care. Persons eligible under current rules could lose coverage due to restricted eligibility standards and/or capped enrollment.
- The Medicaid program establishes certain services as mandatory—these include hospital inpatient and outpatient services, and nursing home services. If these mandatory services were no longer required, each state would be free to select its own package of services and to exclude even the vital services that currently are considered mandatory.
- Under the dramatic funding cuts anticipated by current "cap" proposals, states would be under tremendous pressure to reduce home and community-based services or tighten eligibility criteria to serve fewer people.
- Access to services could be diminished as provider rates fall to inadequate levels in response to decreased federal funding and oversight.

2. Unaffordable Financial Obligations

- Current law allows beneficiaries to retain a home, and protects spouses from being completely impoverished by the expense of caring for a person who can no longer live independently. These financial protections could disappear under the "cap" proposals.
- Low-income older Americans risk being saddled with unaffordable bills. Current law limits Medicaid providers from charging more than certain amounts, but those federal protections could disappear.

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3 Molly O'Malley Watts et al., Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015, Figure 2 (Kaiser Family Foundation 2016), available at kff.org/medicaid/report/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015/.

4 CMS, National Health Expenditures by Age and Gender, Table 3, available at cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Age-and-Gender.html.

- Persons eligible for both Medicaid and Medicare may face unaffordable Medicare cost sharing obligations. Current law requires Medicaid programs to cover Medicare cost sharing, but this requirement could disappear under current proposals.

3. Lessened Quality of Care

- The federal Nursing Home Reform Law has maintained nationwide nursing home standards since 1990, but those standards would not necessarily apply under the "cap" proposals.

Medicaid Protects Low-Income Older Americans

Medicaid covers vital health care that persons otherwise cannot afford.

The Medicaid program provides health care coverage to low-income persons who otherwise cannot afford needed health care services. One path to eligibility is age—specifically, being age 65 or older. Currently over six million seniors are Medicaid-eligible nationwide.[5]

These older persons can be eligible for Medicaid coverage if their savings are extremely low—no more than $2,000 in many states, for example. Income also is relevant, because Medicaid rules allow beneficiaries to have income only up to a specified amount. This amount varies from state to state, but often is tied to the federal poverty level.

Medicaid—not Medicare—provides services when older adults no longer can live independently.

In addition to Medicaid, the Medicare program also provides health care coverage for older Americans. Medicare coverage does not require limited savings or income; instead, Medicare eligibility requires sufficient years of work (with payroll contributions to the Medicare program) from the person or the person's spouse.

Although the Medicare program provides strong coverage in many ways, it also has significant holes. One major gap is Medicare's extremely limited coverage for services needed when someone no longer can live independently. The Medicare program focuses nearly exclusively on acute care services, and provides very limited assistance for long-term services and supports such as assistance with activities of daily living.

Mrs. Rodriguez has Alzheimer's disease, and needs several daily hours of assistance in order to dress, bathe, and eat. Federal Medicaid law gives states the option of developing programs to provide the necessary assistance at home. For example, through waiver programs, states can provide personal care services and assistance for family caregivers. By contrast, the Medicare program has no mechanism to provide the needed assistance.

The same discrepancy is present when necessary services are provided in a nursing home. The Medicare program pays for nursing home services under extremely limited conditions: only when those services are a follow-up to acute-care hospitalization, only when the person is receiving heightened nursing or rehabilitative services and, in any case, only for a maximum of 100 days. Medicaid, on the other hand, can cover nursing home services indefinitely, with the recognition that the person no longer is able to live at home, and cannot afford to pay privately for the necessary care. Nursing home care on average costs over $82,000 annually,[6] and few persons can afford this level of

5 Molly O'Malley Watts et al., Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015, Figure 2 (Kaiser Family Foundation 2016), available at kff.org/medicaid/report/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015/.

6 Genworth Cost of Care Survey, available at genworth.com/about-us/industry-expertise/cost-of-care.html.

expense on an ongoing basis. As a result, 63% percent of nursing home residents are Medicaid-eligible.[7]

Medicaid assists low-income older Americans in paying Medicare premiums, deductibles, and copayments.

The Medicare program requires significant financial contributions from beneficiaries. Medicare Part B (which covers physician visits and other outpatient services) imposes a standard monthly premium of $134, an annual deductible of $183, and a 20% copayment. Medicare Part A (covering inpatient care) imposes a $1,316 deductible for each benefit period. In Part D (covering medication), the monthly premium varies depending on the health insurer, and a "donut hole" in the coverage imposes additional costs on the beneficiary when a certain cost level is reached.[8]

As discussed above, Medicaid beneficiaries by definition have very limited savings, and barely enough income to cover their monthly expenses. Older adults in poverty and at risk of poverty rely on the Medicaid program to assist them in paying the premiums, deductibles, and copayments required by the Medicare program. Medicaid eligibility also automatically qualifies individuals for assistance with Medicare's Part D medication coverage.

Medicaid is a Joint Federal/State Program that Gives States Significant Flexibility to Individualize their Programs

Medicaid programs combine federal and state funding.

Medicaid programs operate with a combination of federal and state funds. Under current law, federal funding is based on the number of Medicaid beneficiaries and their needs. Each state Medicaid program offers the services required by federal Medicaid law, along with whatever optional services that state wishes to offer. Beneficiaries then are covered for the specified services as long as the services are prescribed by a physician (as necessary), determined to be medically necessary by the Medicaid program, and provided by a certified person or entity. The federal government covers a specified percentage of the total cost, and the state is responsible for the remainder.

The federal contribution rages from 50% to 74.63% of the total, depending on the state's average personal income.[9] Those states with the highest average personal incomes receive the 50% federal contribution; those states with lower average incomes receive a greater percentage contribution.

Federal Medicaid law sets certain basic standards, with states having discretion to add additional services or eligibility categories.

State Medicaid programs must follow certain mandatory standards set by federal statute and regulation. Beyond those mandatory standards, however, state Medicaid programs have significant discretion to individualize their programs to address a state's needs and preferences. Each state develops a detailed state Medicaid plan, and then revises that plan as necessary to respond to changed conditions. The state plan must be approved by the federal government, to ensure compliance with the federal minimum requirements.

For example, certain Medicaid services are mandatory—these include inpatient and outpatient hospital services, physician services, rural health clinic services, and nursing home services. Certain other services are optional—these include private duty nursing services, physical therapy, and dental services. A state adopts an optional service by

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7 Charlene Harrington & Helen Carrillo, Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2014, at 1, 8 (Kaiser Family Foundation 2015), available at kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2014/.

8 A provision of the Affordable Care Act gradually reduces the impact of prescription medication "donut hole." Affordable Care Act, § 3301.

9 80 Fed. Reg. 73,779 (2015).

making the choice in the state plan.

Likewise, certain eligibility categories are mandatory, while others are optional. For example, a state Medicaid program must provide coverage to older Americans who are eligible for Supplemental Security Income (SSI), but has the option of providing coverage for older Americans with incomes up to the federal poverty level.[10] A state makes these choices in its Medicaid state plan. Importantly, the current design of the Medicaid program encourages states to provide optional services, because federal matching funds are available for both mandatory and optional services.

Federal Medicaid law authorizes additional flexibility for state innovation and experimentation.

Under federal Medicaid law, a state can request waivers to provide additional services or to experiment with certain program features. Through a home and community-based services (HCBS) waiver, a state can provide a package of services that enable Medicaid beneficiaries to live at home rather than in a nursing home. These waivers are widespread: over 1.5 million Medicaid enrollees in 47 states and the District of Columbia were served through HCBS waivers in 2013.[11] The package of services commonly includes personal care services, meal delivery, assistance for family caregivers, and home modifications. HCBS waivers are a win-win arrangement: the Medicaid program pays less than it would have paid for nursing home care, and the older person receives necessary services at home.

Federal law also allows for demonstration waivers that are can accommodate many types of program modifications requested by a state Medicaid program. These waivers must be designed to be "likely to assist in promoting the objectives" of federal Medicaid law.[12]

Medicaid Funding Caps Would Limit Medically Necessary Care for Older Americans.

Medicaid funding caps would degrade coverage by imposing a rigid limit on federal monies.

Recent proposals to change the structure of Medicaid have focused on two related but different concepts: block grants and per capita caps. For example, Trump Administration officials have discussed block grants as a component of the President's proposal to replace the Affordable Care Act, and block grant proposals were included in President Trump's campaign position paper regarding healthcare.[13] The Fiscal Year 2017 budget proposal introduced by Rep. Tom Price (R-GA), the President's nominee to head the Department of Health and Human Services (HHS), also included block grants and per capita caps.[14] House Speaker Paul Ryan (R-WI) relies heavily on block grants and per capita caps to restructure the Medicaid program in his "Better Way" proposal.[15]

In a block grant, a state receives a lump sum with great discretion on how to spend it. If Medicaid were converted to a block grant, each state would receive a payment of federal funds based in some way on the state's past Medicaid expenditures, with some type of inflation adjustment for subsequent years. In proposals released to date, this funding would not necessarily keep up with health care costs, or vary based on the number of persons served.

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10 For a single individual, the current SSI rate is $735 monthly, and the current federal poverty level is $1,005 monthly.

11 Terence Ng & Charlene Harrington, Medicaid Home and Community-Based Services Program: 2013 Data Update, at 1 (Kaiser Family Foundation 2016), available at kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

12 42 U.S.C. § 1315(a).

13 Healthcare Reform to Make America Great Again, available at donaldjtrump.com/positions/healthcare-reform.

14 Committee on the Budget of the U.S. House of Representatives (Chairman Tom Price, M.D.), A Balanced Budget for a Stronger America: Fiscal Year 2017 Budget Resolution, at 26.

15 A Better Way: Our Vision for a Confident America, at 25-28, available at abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

In developing its Medicaid program, a state would have wide discretion to determine which persons to cover, which services to provide, and which eligibility standards to follow. Current federal requirements and standards are not guaranteed.

A per capita cap is similar, except that the set amount would be paid on a per-beneficiary basis. Overall federal contributions would rise if enrollment increased, but the amount paid per enrollee would likely grow at a rate lower than the health care inflation rate. Under proposals released to date, the program likely would distinguish between certain types of Medicaid beneficiaries—for example, the federal government would pay a certain amount for each child eligible for Medicaid, and a different amount for each eligible older person. However, the funding levels under per capita caps would still be structured to decrease federal funding overall, which would place pressure on state budgets and lead to decreased services for individuals.

Capping Medicaid funding could deprive Medicaid beneficiaries of medically necessary care.

In current Medicaid law, a key protection for Medicaid beneficiaries is the requirement that access to care be based on medical necessity. But this protection could be lost if federal funding were to be capped. Increased state "flexibility" could allow states to impose additional requirements before care is provided, even if that care was medically necessary. Under either a block grant or a per capita cap, a state Medicaid program could deny medically necessary care on the grounds of inadequate funding.

Deprivation of services would be a certainty given the magnitude of federal funding cuts contemplated by cap proponents. Rep. Price, nominated to lead HHS, proposed to spend approximately $1 trillion less on Medicaid over ten years, or an average cut of $100 billion annually. Furthermore, over the ten years, the proposed cuts represent a 23 percent reduction in federal Medicaid funding.[16] Cuts of that magnitude cannot be absorbed by providing services with greater efficiency, and instead would require dramatic reductions in the availability of health care for older Americans and other Medicaid beneficiaries.

"Flexibility" in current proposals would be used to reduce coverage and services.

In general, Medicaid "cap" proposals claim that increased state flexibility will allow states to provide equivalent or improved Medicaid services with less expense.[17] This claim does not withstand scrutiny. As discussed above, the proposed cuts are simply too great to be offset by program efficiency, and nothing in the proposals provides any evidence for a claim that such savings are achievable through increased efficiency.

In fact, the evidence suggests the opposite. The Centers for Medicare & Medicaid Services (CMS) states the matter simply: "Medicaid is the most efficient health coverage program we have, covering people at lower cost than commercial insurance coverage or even Medicare."[18] For example, CMS and state Medicaid programs have worked together in recent years to increase automation and streamline eligibility determinations and enrollment.[19]

Furthermore, as discussed above, Medicaid itself allows for considerable flexibility, within guidelines ensuring that the flexibility is exercised to improve health care for beneficiaries. Home and community-based services waivers

16 Rep. Price proposed to spend $3.441 trillion over ten years for Medicaid and other health care (not including Medicare), which is $1.028 trillion less than what otherwise would be spent. Committee on the Budget of the U.S. House of Representatives (Chairman Tom Price, M.D.), A Balanced Budget for a Stronger America: Fiscal Year 2017 Budget Resolution, at 48-49.

17 See, e.g., Healthcare Reform to Make America Great Again, available at donaldjtrump.com/positions/healthcare-reform; Committee on the Budget of the U.S. House of Representatives (Chairman Tom Price, M.D.), A Balanced Budget for a Stronger America: Fiscal Year 2017 Budget Resolution, at 26; A Better Way: Our Vision for a Confident America, at 25-28, available at abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

18 CMS, Medicaid & CHIP: Strengthening Coverage, Improving Health (Jan. 2017), at 3, available at medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

19 CMS, Medicaid & CHIP: Strengthening Coverage, Improving Health (Jan. 2017), at 8, available at medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

allow state Medicaid programs to design individualized benefit packages and—in recognition of the difficulties faced by persons who can no longer care for themselves—expand financial eligibility requirements. Similarly, demonstration waivers give states broad latitude to innovate, as long as program modifications are "likely to assist in promoting the objectives" of federal Medicaid law.[20] In 2015, there were 55 approved demonstration projects in 38 states.[21] For example, demonstration waivers have been used by 13 states to combine and coordinate Medicare and Medicaid benefits for up to two million older Americans eligible for both programs.[22]

Flexibility can be positive for Medicaid programs and beneficiaries, but only if the flexibility is bounded in a way that ensures consistent focus on access and quality. In current "cap" proposals, however, flexibility is not bounded in any way, leaving the door open for "flexibility" to be used to restrict eligibility and services. As discussed above, the budget of Rep. Price anticipated a 23% reduction in federal Medicaid expenditures over a ten-year period. Particularly given state budgetary pressures, and the oftentimes limited political clout of low-income persons, decreased funding and unfettered flexibility in state Medicaid program would inevitably result in fewer persons with Medicaid coverage, and in reduced services for those persons who remained eligible.

Current "Cap" Proposals, if Implemented, Would Harm Low-Income Older Americans.

As discussed above, the current Medicaid "cap" proposals combine two primary features: capped federal reimbursement, and the elimination of longstanding consumer protections. Because limited state budgets are a reality, and low-income persons have relatively limited political power, the "cap" proposals inevitably would result in real-world harm to low-income older Americans. They would have access to fewer services, be saddled with unaffordable financial obligations, and receive a lesser quality of care.

Loss of Eligibility and Services

Medicaid beneficiaries could lose coverage.

Current federal Medicaid law requires coverage of certain low-income populations. For older Americans, one mandatory coverage group includes those persons who have monthly incomes of no more than $735 and available assets of no more than $2,000, and who thus are eligible for Supplemental Security Income (SSI). Another mandatory eligible group includes persons with slightly higher incomes who are eligible for a State Supplementary Payment (only certain states offer SSP). Under the proposed "cap" proposals, states could deny eligibility to these older Americans, regardless of their indisputably meager financial resources. States with more expansive eligibility criteria today could cut their programs, taking away access to vital health care services for their older residents.

States also might choose to cut expenses by capping enrollment. In general, current Medicaid law does not allow numerical limits on enrollment—if an applicant meets financial and clinical eligibility standards, he or she is entitled to coverage.[23] In the "cap" proposals, however, nothing prevents a state from capping enrollment at a certain number of persons. Such a limitation would deprive many vulnerable persons of needed health care services.

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20 42 U.S.C. § 1315(a).

21 Report to Congress, The U.S. Department of Health and Human Services' First Report on Section 1115(a) Demonstrations: Transparency in the Review and Approval of Medicaid and Children's Health Insurance Program (CHIP) Section 1115 Demonstrations (Oct. 2015), at 4, available at medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/1115-transparency-rtc.pdf.

22 State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries (Kaiser Family Foundation 2015), available at kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/.

23 HCBS waivers and demonstration waivers are an exception, because the waiver document can provide for certain enrollment limits.

Beneficiaries could lose access to currently mandatory services such as nursing home care.

Mandatory services under Medicaid include inpatient and outpatient hospital services, physician services, and nursing home services. For older Americans, access to nursing home services would be particularly at risk under the "cap" proposals. Unlike hospital services and physician services, long-term nursing home care is not covered under Medicare. Also, nursing home care is a costly benefit, making it a potential target for a state looking to cut back on Medicaid expenses.

Currently, over 1.3 million Americans reside in nursing homes nationwide.[24] Access to nursing home care would be at risk under any proposal that does not require that a state Medicaid program provide any particular service or package of services.

States could be forced to cut services that allow older Americans to stay at home.

States currently provide a range of services that allow older adults and people with disabilities to remain in their homes rather than going to a nursing home or other institution. In 2013, almost three million older adults and people with disabilities received such services, with a total expenditure of over $56 billion.[25] CMS has been encouraging states to provide more home-based care for their most vulnerable seniors, and providing the matching funds to make that possible. However, under the dramatic funding cuts anticipated in current block grant and per capita cap proposals, states would be under tremendous pressure to reduce such services or tighten eligibility criteria to serve fewer people. Without the necessary federal support, states could be forced to give up these innovative and important programs.

Access to services could be diminished by inadequate provider rates.

Current Medicaid law obligates state Medicaid programs to pay a rate sufficient to attract an adequate number of health care providers. CMS retains oversight to ensure that rates and provider networks are sufficient.[26]

The "cap" proposals, however, send money to the states without any requirement or structure to ensure adequate payment rates. State budgetary pressures, which already push down Medicaid reimbursement rates, would be even more likely to result in inadequate rates, which in turn would result in beneficiaries not having access to services, or in having an extremely limited choice of providers.

Unaffordable Financial Obligations

Medicaid applicants could be forced to sell their homes or other previously protected possessions.

Under current Medicaid law, several types of possessions are not counted against the Medicaid resource limit, which is commonly in the range of $1,500 to $3,000. A home is the most prominent type of "exempt" resource. An applicant is not required to sell his or her home in order to obtain Medicaid coverage although, after the beneficiary's death, Medicaid programs frequently have authority to obtain repayment from the home's value. Under the "cap" proposals, however, a home would not be automatically protected, and a state Medicaid program could require that a home be sold as a prerequisite to eligibility.

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24 Total Number of Residents in Certified Nursing Facilities (Kaiser Family Foundation: 2014 (Kaiser Family Foundation), available at kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0.

25 These services include home health services, personal care services, and home and community-based waiver services. Terence Ng & Charlene Harrington, Medicaid Home and Community-Based Services Program: 2013 Data Update, at 1 (Kaiser Family Foundation 2016), available at kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

26 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,575 (2015).

Other exempt resources under current law include a necessary automobile, household goods, wedding rings, and burial funds of no more than $1,500. These items are not protected under the proposed "cap" proposals, and state Medicaid programs could demand their sale as a condition of coverage.

Married couples could be forced into poverty when one spouse requires home and community-based services or nursing home care.

Federal law since 1989 has provided special protections for spouses of those persons who can no longer live independently. This protection has been mandatory for nursing home residents but at a state's option for persons receiving home and community-based services. From 2014 through 2018, however, such protection is mandatory also for HCBS recipients, pursuant to the Affordable Care Act.[27]

Prior to 1989, a need for nursing home care or comparable in-home care could drive a married couple into poverty and/or divorce. Medicaid rules commonly forced the couple to spend their resources down to $3,000, and to spend virtually all of their joint income as a contribution towards the required services. Under spousal impoverishment protections, on the other hand, federal Medicaid law allows the Medicaid beneficiary's spouse to retain a specified allocation of resources and income. Each state sets its allocations within an inflation-adjusted range set by federal law.[28] The range guarantees that each "well" spouse is able to pay for necessary expenses even though the other spouse requires extensive services.

Under the "cap" proposals, states would not be required to offer spousal impoverishment protections and, if they did provide some level of protection, the allocations would not be subject to the ranges currently set by federal law. Once again, as was the case prior to 1989, one person's Alzheimer's disease or stroke could consign his or her spouse to ongoing poverty.

Low-income older Americans could face higher medical bills.

The proposed "cap" programs would expose low-income older Americans to financial risk, by eliminating Medicaid protections that otherwise ensure that health care obligations are affordable. Current Medicaid law obligates a Medicaid provider to accept Medicaid reimbursement as payment in full. Thus, the provider cannot bill a Medicaid beneficiary for the full private-pay amount, or for any shortfall between the Medicaid reimbursement rate and the private-pay rate. This federal rule could be jettisoned if states were given complete discretion to design their own Medicaid programs, and beneficiaries would be at risk of being billed for services far beyond their ability to pay.

Beneficiaries would also face financial risk relating to Medicare cost sharing. Current Medicaid rules also require that states offer Medicare Savings Programs that provide premium and co-insurance protection for low-income persons. As detailed above, this cost sharing can be significant—for example, Medicare Part B requires beneficiaries to pay 20% of the cost for outpatient services.

If states are provided increased discretion under block grants and per capita caps, they could decide not to offer these programs. As a result, older Americans with both Medicare and Medicaid coverage could find themselves held responsible for Medicare cost sharing far above their ability to pay. This would make health care unaffordable for them, and result in greatly decreased access to care.

Lessened Quality of Care

Nursing home residents could be endangered by poor care.

In 1986, the Institute of Medicine reported on persistent substandard care in the country's nursing homes.[29]

27 Affordable Care Act, § 2404.
28 42 U.S.C. § 1396r-5.
29 Institute of Medicine, Improving the Quality of Care in Nursing Homes (1986).

Congress responding by enacting the Nursing Home Reform Law, which President Reagan signed into law in 1987, and which became effective in 1990. Under the Reform Law, a nursing home must comply with the federal requirements as a condition of receiving Medicaid reimbursement. Requirements include a certain array of services, nurse staffing standards, protections against resident abuse and neglect, resident rights, protections against eviction, and many other provisions.[30] Government surveyors inspect each facility annually, and conduct additional investigations in response to consumer complaints.

The "cap" proposals, however, evidently allow states to design their own Medicaid programs, and thus may not retain the Reform Law. Quality of care would suffer, and residents would be at increased risk of infections, bed sores, and other negative and dangerous outcomes.

Conclusion

The Medicaid program is over fifty years old. Its current structure reflects decades of modifications, and a relatively nuanced balancing of consumer and provider needs, along with federal and state budgetary realities.

The current "cap" proposals could erase most of not all existing Medicaid procedures, and replace them with a lax process that gives the states inadequate funding, and tasks them with the requirement of developing new, state-specific Medicaid systems from scratch.

As explained above, the "cap" proposals would cause significant harm to low-income older Americans. The proposals rely on significant cuts to the Medicaid program to achieve federal savings. Under these proposals, older Americans would likely lose services, be saddled with unaffordable financial obligations, and receive a lessened quality of care. The touted "flexibility" of these proposals likely would be used not to innovate, but to eliminate important safeguards.

30 *See* 42 U.S.C. § 1396r.