Center for American Progress

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The Ryan Medicaid Plan

A Threat to Middle Class Security

Scott Lilly July 2011

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Introduction and summary

For more than a decade policymakers in Washington and ordinary citizens across the country have engaged in a public dialogue on the federal budget that has frequently served to confuse rather than clarify the choices facing our nation. This year Rep. Paul Ryan (R-WI), chairman of the House Budget Committee, put forward a proposal that attaches significantly greater programmatic detail to the spending reductions he is proposing than previous advocates of large spending cuts. The proposal has been both praised and assailed for its content—but there is little question that it has served to move the budget debate to a more substantive and informative level.

The Ryan plan is important not simply because it provides greater detail as to how cuts in federal spending might be achieved but also because it has legislative credibility. On April 15, 2011 the Ryan budget was adopted by the U.S. House of Representatives by a vote of 235 to 193, with all but four members of the majority party (the Republicans) voting "yes."

This paper examines one key proposal in the Ryan budget plan that has thus far received surprisingly little attention—the proposal to replace the current Medicaid program with block grant payments to states. The Medicaid changes would have extraordinary implications not only for the poor individuals who are normally thought of as the principal beneficiaries but for a very broad swath of middle-class families who are far more likely to become reliant on Medicaid benefits at some point in their life than most currently realize.

A full public discourse on whether the Congress should go forward with these particular cuts as opposed to other policy options available to the Congress requires some in depth probing as to what impact the cuts would likely have on various segments of the population, and whether or not the public at large would be comfortable with the risk that those benefits might disappear. It is also necessary to view the value of these benefits in comparison with other options that might be available to Congress and in particular, the overall policy direction of the

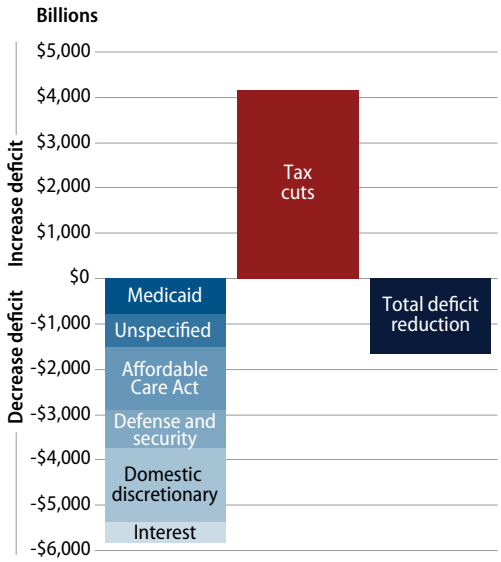
broader Ryan proposal—a proposal that not only includes the permanent extension of the Bush era tax cuts but the adoption of additional tax cuts, including the lowering the top individual income tax rate from 35 percent to 25 percent.

Overall the proposal includes $5.8 trillion in spending cuts (relative to the Congressional Budget Office baseline) that are heavily offset by $4.2 trillion in revenue reductions. Net the plan generates only $1.6 trillion in deficit reduction. Medicaid reductions and most other spending cuts can be fairly seen as largely paying for further tax reductions rather than deficit reduction.

As a result, the federal budget will remain in deficit throughout this period and the public debt will grow by $5.8 trillion. That is less than the $7.4 trillion worth of debt that would accumulate if no deficit reduction plan were adopted, but far less than one might assume given the magnitude of spending cuts Rep. Ryan is proposing.

FIGURE 1

Ryan budget proposal



Source: Ryan Budget Summary Tables, Table S2 House Budget Committee.

What does this mean for Medicaid? Under the Ryan plan, Medicaid accounts for $771 billion in spending cuts over the 10-year period of the proposal. That is more than one-eighth of the total cuts in the plan—many times more than the cuts in Medicare. Nonetheless, the Medicaid portion of the package has received far less attention than the Ryan proposal for Medicare. Medicaid is in fact the epicenter of the current budget debate.

Perhaps that is because many of us are under the misperception that Medicaid is simply one more benefit for the nation's poor and that we have reached a point when we can no longer afford to be as generous to the poor as we were in the past.

But in fact Medicaid is not really a poverty program. As this paper will demonstrate, two-thirds of Americans living below the federal poverty line are not Medicaid beneficiaries. But the overwhelming majority of families who make up what is generally considered the nation's middle class will be at significantly greater risk of facing financial catastrophe at some point in their lives if these benefits are taken away.

We all know people—or at least know of people—who had their lives changed in a split second. Whether it is an auto accident, the birth of a severely disabled child,

a stroke, or devastating news from the doctor's office, a well-planned and orderly life can be turned upside down almost instantly with grave consequences for not only the immediate victim but friends and family as well.

The medical costs associated with such events can run into hundreds of thousands and even millions of dollars. Many of us are lucky enough to have insurance that will cover most if not all of those costs. But few of us can manage the extraordinary burden of the long-term care requirements that such tragedies often leave in their wake. Few of us could cover such costs if we were the victims and even fewer could make a substantial contribution to the cost of providing such care for a relative that can no longer be cared for at home or in a community setting.

Many elderly and disabled Medicaid beneficiaries once lived in middle class households, and while they make up only 25 percent of Medicaid's enrollees they account for two-thirds of Medicaid spending. It is difficult to envision reductions in Medicaid spending of the magnitude that would be required under the Ryan formula without significant reductions in this portion of the program.

Cutting eligibility for those who are neither elderly nor disabled would also be more problematic than is generally recognized. The overwhelming portion of Medicaid funds going to adults who are neither aged nor disabled goes for prenatal and maternity care and that care is at least partially responsible for the dramatic decreases in miscarriages and infant mortality that have taken place in this country. Reducing the health care available to children would reduce the number who arrive at school ready to learn and would also place the broader population at risk from the stand point of public health.

Finally, this paper will discuss whether the Ryan Medicaid proposal actually resolves the deficit and spending problems we now face or simply relocates them to state capitals. Even if the Ryan proposal to repeal the recently enacted health care legislation is adopted, the cost of providing current levels of service to currently eligible populations will increase by about $337 billion over the next decade. Under the current formula the federal government would pay about $192 billion of that increase leaving the states to pick up the remaining $145 billion.

Ryan would cut the federal contribution to $78 billion, leaving the states with well over a quarter of a trillion in new revenue necessary to fund the current Medicaid program. Under the Ryan proposal the portion of state revenues needed to fund current service and eligibility levels would go from 16 percent at present to 26

percent by 2021. While it is likely that the portion of state revenues going to Medicaid will rise significantly—crowding out other state services such as support for colleges and universities, aid to highways, public health, law enforcement, and the support of local schools —it is not likely that those shifts will resolve the entire shortfall.

As a result, the proposal will also place significant upward pressure on state and local taxes, including sales taxes and property taxes. Combined with the Ryan proposal to lower tax rates on the highest-income federal taxpayers, this will amount to a massive downward redistribution of after-tax income.

Medicaid is a huge program that touches many lives but is nonetheless poorly understood by both the public and policymakers. Perhaps more than any other government program it is the social safety net for middle class families—families that as the result of old age, injury, disease, or some other catastrophic happenstance could face medical and long-term care bills that far exceed what their savings and insurance will cover. Because it insured millions of Americans who got the care that they needed, millions of families did not confront financial disaster.

Changes to this program should be made with extreme caution and not before the public has a clear understanding of the consequences those changes might have on their lives and the lives of their neighbors. In the pages that follow, this paper details the costs and consequences of the Ryan plan as passed by the House of Representatives earlier this year.

The Ryan Medicaid plan

The nonpartisan Congressional Budget Office analyzed Rep. Ryan's Medicaid proposal and described it as follows:

- Starting in 2013, the federal share of all Medicaid payments would be converted into block grants to be allocated to the states. The total dollar amount of the block grants would increase annually with population growth and with growth in the Consumer Price Index for Urban Workers, or CPI-U.

- Starting in 2022, Medicaid block grant payments would be reduced to exclude projected spending for acute care services for elderly Medicaid beneficiaries.

- States would have additional flexibility in designing their programs.[1]

The following three sections of this paper examine the implications of these three changes for Medicaid beneficiaries, their families, and other important services provided by state and local government.

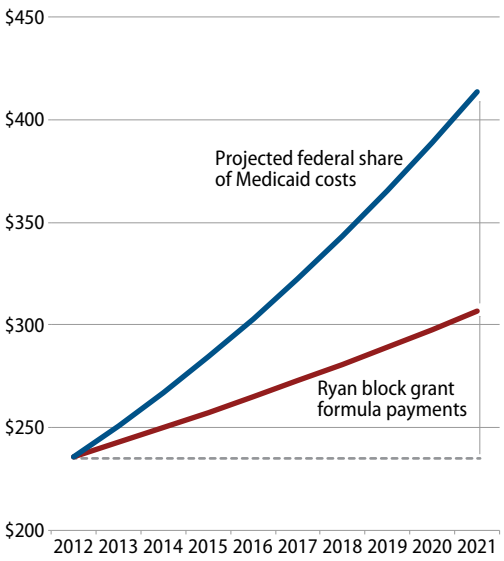
How much would the states get for Medicaid?

CBO estimates that federal spending on Medicaid will total $260 billion in 2012, the last year of the current Medicaid program under the Ryan Plan. Additionally, they estimate in their January, 2011 Budget and Economic Outlook publication that inflation (CPI-U) will increase by 21 percent or about 2.3 percent a year between 2012 and 2021.[2] The U. S. Census Bureau forecasts that the population of the United States will grow at a rate of slightly less than 1 percent per year between 2010 and 2020. Assuming

FIGURE 2

The Ryan block grant formula would cover about 40 percent of the increased program costs between 2012 and 2021

(Does not include expanded eligibility under Patient Protection and Affordable Care Act)



Source: Computed from CBO estimates as explained in Appendix A.

the same rate of growth in 2021, the U.S. population will be about 9 percent larger in 2021 than in base year of the Ryan proposal, 2012.[3]

The upshot: Adjusting 2012 Medicaid allocations to the states for both inflation and population growth would mean that the states will receive about 30 percent more in nominal dollars in 2021 than in 2012 or about $306 billion. (See Figure 2)

Why are Medicaid costs rising so rapidly?

There are a number of factors driving Medicaid costs up much faster than the adjustments the Ryan proposal allows. First, medical costs are rising at a much more rapid pace than the cost for other goods and services in the economy. In the six years between 2003 and 2009, per capita health care spending in the United States is estimated by the Department of Health and Human Service to have increased by 33 percent, from $6,098 to $8,086.[4] Overall inflation during that period as measured by CPI-U increased by only 17 percent during that same period.[5] Health and Human Services, CBO, and private forecasters all project that health costs will continue to rise by about twice the rate of inflation over the decade.[6]

Secondly, the two groups of Americans that account for most of Medicaid spending, the elderly and the disabled are expected to grow faster than the population overall. While the number of disabled persons who qualify for Medicaid will grow about 10 percent faster than the population as a whole, the number of Americans over the age of 65 will increase more than three times as fast. By 2012, the base year for the Ryan proposal, the number of elderly will be 43 million. By 2021 there will be 56 million Americans over the age of 65, a 31 percent increase in a period of eight years.[7] CBO estimates that the number of elderly who qualify for Medicaid will increase by more than 18 percent during that period.[8]

Medicaid has historically paid physicians, hospitals, and other health care providers significantly less than other payers, including private insurers and Medicare. Medicaid's per patient expenses for specific types of enrollees are generally also well below that of other payers.[9] But there is little chance that Medicaid can shrink its reimbursements as a percentage of what private insurers or Medicare are paying since there is already concern that Medicaid rates are currently so low that the program is burdened by the cost of low-quality providers who misdiagnosis and inappropriate treatments that result in repeat visits and unnecessary days of inpatient care.

As a result Medicaid payments will probably remain quite low relative to those of other payers by they are likely to increase at about the same percentage rate.[10] CBO projects that the per enrollee cost of providing health care to children will rise by 42 percent between 2012 and 2021 while the per enrollee cost for the disabled will go up by 56 percent.[11]

Could states continue to provide current levels of Medicaid coverage?

Four sets of Medicaid beneficiaries would be affected by Rep. Ryan's plan to cut the program:

- The elderly
- The disabled
- Lower-income children
- Certain lower- and lower-middle income adults

Each of these groups would be hit in a different way, with profound consequences for our society. So let's take a look at how this plan would play out for each group over the next decade.

The elderly

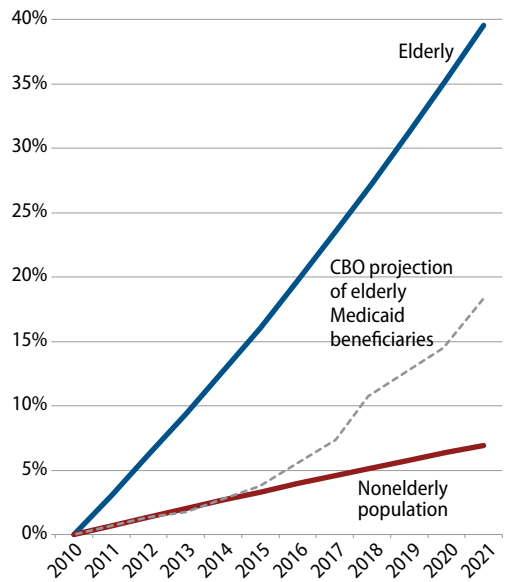
CBO estimates that under current law total Medicaid expenditures for the elderly from both state and federal sources will increase from about $84 billion in 2012, when the Ryan plan would terminate the current program, to $156 billion in 2021, an 85 percent increase. (See Figure 3)

But the Ryan proposal would allow the federal share of those costs to increase by only 30 percent, from $48 billion in 2012 to $62 billion in 2021. To maintain the current level of services to elderly beneficiaries the states would have to increase their contribution from the 2012 level of $36 billion to $94 billion—a $57 billion increase in state costs.[12]

It might be argued that the states could come up with at least a portion of the $57 billion required to maintain current service levels for the elderly by making savings in other parts of the Medicaid program. But a review of how other segments of the Medicaid population will be affected by the Ryan proposal makes that possibility highly problematic. The first case in point: the disabled.

FIGURE 3

Percentage growth of elderly and nonelderly populations, 2010 to 2021



Source: National Population Projections U.S. Census Bureau; Supplemental Data on Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid. Congressional Budget Office.

The disabled

The beneficiary group that accounts for the largest share of expenditures under the Medicaid program is not the elderly but the disabled. According to CBO the $184 billion expected to be spent from state and federal sources on such individuals in 2012 will grow to $333 billion in 2021.[13] Under the Ryan proposal the federal government would assume only $32 billion of that $196 billion increase, leaving a $164 billion gap for states to fill either through reductions in benefits or increases in state contributions.[14]

Even if medical services for the disabled were cut below current levels by one-third, there would be no money available to fill any of the $56 billion gap in funding current services for the elderly.

Of course, many people would question how we could practically cut medical care to indigent individuals who are disabled. Would their relatives be able to care for them? Would large numbers be added to the hundreds of thousands of individuals already living on the streets? If so, this new flood of disabled might increase the nation's homeless population by as much as five fold.[15] Yet if current service levels were maintained for both the elderly and the disabled, then huge cuts would be necessary in the services provided to two other groups of beneficiaries—indigent children and nonelderly or disabled adults, largely the mothers of indigent children. (See Figure 4)

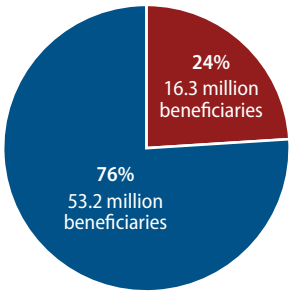
Low-income adults and children

Children currently make up half of all Medicaid enrollees but account for about 22 percent of all benefits. Adult beneficiaries who are not disabled or elderly make up a little more than a quarter of enrollees and account for only 15 percent of costs. Together they constitute 75 percent of all enrollees but only slightly more than one-third of all Medicaid costs.[16]

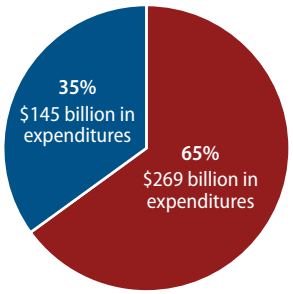
The Patient Protection and Affordable Care Act, which was signed into law last year, would extend Medicaid coverage in 2014 to adults and children whose household income is no more than 138 percent of the federal poverty level but who do not have health coverage and are not currently eligible for Medicaid. Rep. Ryan proposes to repeal that act and provides no funds to the states to allow extension of coverage to any of the approximately 20 million people who might be added to the Medicaid rolls by that legislation.

FIGURE 4

This year the elderly and disabled will make up 24 percent of all Medicaid *beneficiaries*



This year the elderly and disabled will make up 65 percent of all Medicaid *expenditures*



Elderly and disabled

Children and nonelderly or disabled adults

CBO projections of future year Medicaid costs are based on current law and assume the expansion of beneficiaries contained in the new health law. If, however, one assumes (as Rep. Ryan does) that the health care reform legislation will be repealed and that the number children and adults who qualify for Medicaid will expand at only the same pace as the population—the cost of providing current levels of coverage will be $262 billion.[17] Rep. Ryan's block grant proposal would pay $108 billion of that total, leaving the states to pick up the remaining $155 billion or cut beneficiaries and services.

Currently, states spend $62 billion from their own revenues on these beneficiaries so avoiding cutbacks would require a 150 percent increase in spending from state revenues. If no increase were provided it would require a cut equal to the elimination of a third of projected beneficiaries—that would be about 13 million children and 6 million mothers.

While that would balance the books as far as the children and adult portions of Medicaid are concerned it would provide no savings to mitigate the problems already discussed with respect to cutting benefits for the elderly and disabled. States would need to divert funds from programs other than Medicaid if those problems were to be addressed.

It should also be noted that the Ryan proposal would not only leave the 20 million who would gain Medicaid coverage under the Affordable Care Act in the ranks of the uninsured but under this scenario increase the number of uninsured by another 20 million—swelling their ranks to somewhere between 60 million and 70 million with profound implications for health providers, insurers, and those who purchase private insurance coverage for themselves or their employees.

There is little question that Medicaid health care coverage provided to poor children and able-bodied adults is both the most controversial and the most politically vulnerable portion of the program. Some argue that it is merely an extension of a welfare philosophy that provides assistance to those who don't have the initiative to make their own way, and further that providing such assistance reduces the inclination of the recipients to take responsibility for their own needs. It is not the purpose of this paper to resolve that controversy, but it should be pointed out (as will be discussed greater detail later in this paper) that there are arguments for providing such assistance that go beyond the needs of the beneficiaries and address larger interests of society.

Perhaps the most compelling is that a very big portion of Medicaid expenditures for adults are directed at prenatal and maternity care and reducing the availability of such care would result in the loss of innocent life and increase the burden on society and taxpayers because of lasting consequences of inadequate prenatal and maternal medical care. Since low-income women have no other options for health care, the elimination of this coverage is likely to bring about significant increases in the incidence of low birth weight babies, infant mortality, and infants with permanent disabilities related to inadequate prenatal care and unskilled delivery—all of which will prove extremely expensive to society in the long term.[18]

A broader look at state fiscal realities

A major talking point for Rep. Ryan and supporters of his plan is that it would give states "greater flexibility." Unfortunately, the governors and legislatures will discover that flexibility will need to be directed at making some very painful choices.

As the economy grows, states will have more revenue to deal with fiscal issues such as how to finance Medicaid. CBO projects that our national gross domestic product will be about 50 percent higher in nominal or noninflation adjusted terms in 2021 than in 2012 when the Ryan proposal would convert Medicaid to block a grant. State tax collections from all sources are projected by the National Association of State Budget Officers to be equal to slightly more than a $1 trillion this year or slightly less than 7 percent of GDP.[19]

So if state revenue collections could continue to equal that percentage of GDP over the next decade revenue from state tax collections (excluding federal grants and other payments) would rise to $1.1 trillion in 2012 to and more than $1.6 trillion by 2021. But there are good reasons to expect that will not happen. According to the National Conference of State Legislatures, sales taxes represent 32 percent of all revenues collected by state governments. But Census Bureau data indicate that state collections of those taxes, which totaled 2.3 percent of GDP in 2000, had declined to about 2.0 percent of GDP by 2010.

Property taxes are for the most part dedicated to the finance of local rather than state government, but state governments are often forced to fill the gaps when local government financing falls short. As property values skyrocketed in the first seven years of the past decade, property tax collections nearly doubled. As a percentage of GDP property tax collections rose from 2.5 percent of GDP to more than 3.3 percent by 2009—adding $188 billion to state and local revenue and accounting for about 9 percent of combined state and local revenue in that year.

There is little question that revenue collections from property taxes will decline in coming years both as a share of GDP and in nominal terms. Property values will remain weak and both residential and commercial construction will trail the growth of virtually every other sector of the economy. If property tax collections as a share of GDP were to return to more historic levels by 2021, it would mean a loss of nearly $200 billion in state and local revenue.

If, however, these factors are discounted and we assume that state revenues will keep pace with the growth of GDP, the states will have $1.67 trillion in general and dedicated revenues to spend from the taxes and fees that they themselves levied. In addition, the states would have the $306 billion they would receive in federal Medicaid block grant funds under the Ryan proposal and additional federal funds from the federal government for education, transportation, income security, community development, and criminal justice.

While Rep. Ryan's budget documents provide little information on the specific funding levels that might be expected for state grant programs other than Medicaid, the Ryan proposal does provide a clear indication of the direction such funding will take. The details can be found in the numbers presented for future year funding of the so-called "functional categories" of federal spending.[20]

For instance, a very high percentage of federal money that is spent in the functional category called Education, Training, and Social Services is state grant money. Rep. Ryan projects that under his plan federal outlays for that category will be $81 billion in 2021.[21] That is $46 billion or 36 percent below 2010 levels. That is also less than the outlay level for those programs in any year since 2002.

Transportation is another functional category made up largely of state grant funding—the largest program being the Highway Trust Fund. Rep. Ryan would fund the transportation function at $77 billion in 2021, down from $91 billion last year.[22] Seventy-seven billion dollars is less than the federal government has spent for highways in any year since 2007. Similarly, outlays for community and regional development, which were $24 billion last year, would decline to $12 billion by 2021 under the Ryan budget—the lowest level since 2001.[23]

Most other state grant programs are clumped into functional categories in which a majority of the spending is for services and activities directed at the federal level. As a result, projecting the assumed level of funding for state grant programs is more problematic. We do know, however, that many of the state grant programs

found in these categories, such as community oriented policing services and juvenile justice, have already been singled out for deep cuts in fiscal year 2011 appropriations and are likely to be subjected to further cuts in 2012.

These numbers would suggest that states will not only fail to get adjustments for inflation and population growth in the non-Medicaid grants they receive from the federal government but also are likely to see a decline of more than one-third in such grants, pushing funding levels back to or below the $220 billion level that states received in fiscal year 2008.

The bottom line: If states' collected revenues kept pace with overall economic growth, if states receive the $306 billion promised under the Ryan Medicaid block grant formula, and if non-Medicaid grants to states are whittled back along the lines of the above discussion, then states should have a little less than $2.2 billion to spend in 2021 on all government activities and services.

Other demands on state resources

The Congressional Budget Office has provided us with data that allows us to estimate that states will need about $747 billion to fund Medicaid services at current levels of eligibility in 2021, excluding the new beneficiaries that would be made eligible under the new health law.[24]

The current level of state government activity in areas other than Medicaid continue to be driven by federal funding enacted two years ago to foster economic recovery. The American Recovery and Reinvestment Act of 2009, which was signed into law in the middle of fiscal year 2009 ending in September 2010, did not have a significant impact on state outlays until FY 2010. If one assumes that states will return to providing services in non-Medicaid programs that would be no higher than that provided prior to the passage of ARRA and maintain that level over the remainder of the current decade—adjusting for both inflation and population growth—then $1.7 trillion would be required.

Adding that $1.7 trillion to the projected cost of Medicaid means that states will need more than $2.4 trillion—more than $200 billion above the generously projected revenue levels just discussed. States now spend $177 billion of their own funds on Medicaid, which is equal to 16 percent of all state collected revenue.[25]

In order to continue the current Medicaid program through 2021, they would have two and a half times that amount or about $440 billion from state-generated revenues. In that case, the share of state-generated revenues going to Medicaid would rise from 16 percent to 26 percent. The state share of total Medicaid costs would rise from 43 percent to 59 percent.

Under that scenario, funding for all other state services ranging from elementary and secondary education to highways, law enforcement, and the support of state colleges and universities would necessarily drop from 84 percent of state-generated revenues to 74 percent.

Transferring the federal budget crisis to the states

States will undoubtedly respond in a variety of ways to the pressures these numbers suggest. One option is to raise taxes—and that may well be necessary. In fact it may be necessary simply to reach the level of revenues assumed in this paper given the expected weakness in sales and property tax collections. The irony this presents is that the massive tax cuts ($4.2 trillion over 10 years) Ryan is proposing at the federal level will to some extent ultimately be offset by tax increases at the state and local level.

This represents more than simply a shift in the jurisdiction responsible for levying and collecting the taxes. It also represents a major shift in who pays the tax. Ryan's proposal to reduce the top federal income tax bracket from 35 percent to 25 percent would have the largest impact on people in the top tax bracket which currently begins at $379,000 a year.[26] A couple with $1 million in taxable income would save about $78,000 a year in taxes while families with annual incomes of less than $140,000 would save nothing. By comparison, studies indicate that in states that rely heavily on sales and property taxes, families at the poverty line pay about 17 percent of their income in state taxes while the wealthiest families pay as little as 3 percnt.[27]

FIGURE 5

Growth in cost of current medicaid program 2012–2021

Total federal-state Medicaid expenditures for current eligibility—excluding eligibility expansion under Patient Protection and Affordable Care Act

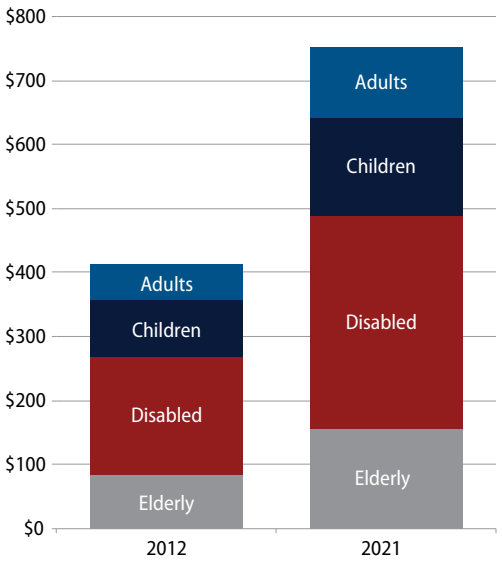
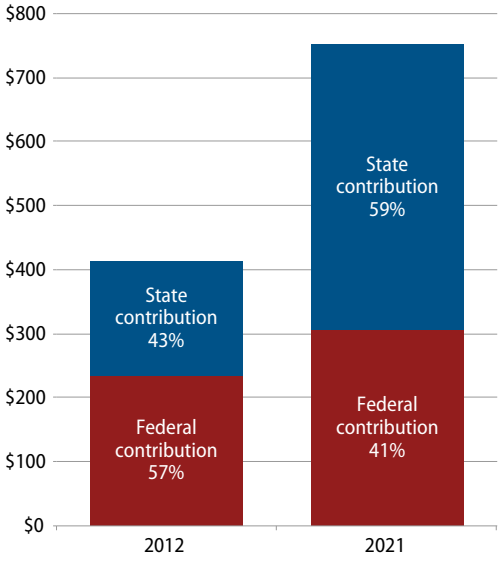


FIGURE 6

Sharing the cost medicaid growth under Ryan 2012–2021

Total federal-state Medicaid expenditures for current eligibility—excluding eligibility expansion under Patient Protection and Affordable Care Act



Another option would be to cut back all other non-Medicaid state services. While there is little doubt some cutbacks in non-Medicaid services are likely in most states, it is also clear that few, if any, states will accept a retrenchment in priorities such as education and transportation (which together account for more than half of non-Medicaid state spending) in order to sustain current Medicaid service levels.

As the preceding discussion indicates, maintaining the 2008 level of non-Medicaid services will cost $1.8 trillion by 2021. A 10 percent cut would produce $180 billion or $20 billion short of the amount needed to fill the Ryan hole.

What Medicaid services would be cut?

If states were willing to make only small reductions in education, highways, and other non-Medicaid services, then massive changes would be required in Medicaid eligibility and benefits to close the gap.

One option that some may put forward is a signicant reduction in eligibility and benefits for children and adults who are neither elderly nor disabled. While that could eliminate as much as 75 percent of Medicaid beneficiaries, it would provide proportionately far less savings since this group accounts for only a third of Medicaid total spending. In fact to fully close the $200 billion plus state fiscal gap discussed in the previous section it would require stripping eligibility from about 40 million of the 60 million adults and children left on Medicaid after the new health care legislation is repealed.[28]

That would pose a number of serious problems that should be weighed carefully.

First, a major reduction in the availability of health care for low-income individuals and in particular, low-income children would have implications for the health of all Americans. Children who are not vaccinated are far more likely to contract diseases such as meningitis epiglottitis, Polio, and Hepatitis B and spread those diseases to others. Further increasing the numbers of individuals and in particular the number of children who do not have access to physicians greatly complicates the nation's capacity to detect and contain the outbreak of pandemic contagions.

But an even bigger problem for children would be the dramatic reduction in prenatal and maternity care that would be provided to their mothers. As discussed earlier, a very large share of Medicaid spending goes to elderly and disabled persons who may very well have not come from low income households. It is also true that most poor people are not Medicaid beneficiaries. Analysis of Current Population Survey Data indicates that only about one-third of Americans living in poverty are Medicaid beneficiaries.[29]

Single individuals and childless couples don't qualify for Medicaid no matter how poor they are. (This would change under the new health care law.) But pregnant women without health care coverage—not only those below the poverty line but those with incomes well above the poverty line—are eligible for prenatal, maternity, and postnatal care. The portion of Medicaid directed toward nonelderly and nondisabled adults is in fact largely a maternity and well-baby program,[30] covering 64 percent of the maternity-related hospital stays of women under the age of 25 and 33 percent of such hospital stays of women between the ages of 25 and 34.[31]

The results of this care have been stunning. When Medicaid was enacted in 1965, the infant mortality rate was 24.7 per thousand live births. In addition, American women lost 28 of every thousand unborn children even after they had survived 28 or more weeks of pregnancy. By 1973 the infant death rate had dropped to 17.7 per thousand, and the perinatal, or pre-birth, mortality rate had dropped to 20 per thousand—both declining by more than a quarter in only seven years. Today we lose fewer than seven unborn children per every thousand pregnancies that go past 28 months, and fewer than seven infants per thousand live births.[32]

Reducing eligibility for prenatal, maternity, and postnatal care would undoubtedly cost hundreds perhaps thousands of lives of infants and unborn children. Denying such care can be expensive not only in terms of lives but dollars. A study on the effects of denying prenatal benefits to undocumented immigrants in California published in *The American Journal of Obstetrics and Gynecology* sheds some light on the consequences of restricting Medicaid eligibility for prenatal care. The study found that women without prenatal care "were nearly 4 times as likely to be delivered of low birth weight infants."[33] A 2009 Report by the March of Dimes Foundation found that the average cost for delivery of a low weight baby was $49,000, or more than 10 times the cost of a baby born without complications.[34]

But the high cost of caring for such babies at birth is only the beginning of the expenses they are likely to impose on their families and society and the Medicaid program. A 2002 survey of scientific literature on very low birth weight babies by the Agency for Healthcare Research and Quality of the Department of Health and Human Services found that, "Surviving premature infants often sustain multi-organ system complications that may persist beyond the first few years of life and frequently result in permanent impairments. Complications of even a single organ system may have a profound impact upon other organ systems." The research reviewed by the Agency for Healthcare Research found elevated levels of seeing disorders, blindness, disabilities of speech and language hearing loss, cerebral

palsy, behavioral disorders, bronchopulmonary dysplasia, and asthma. Numerous studies indicated that very low birth rate babies have high rates of cognitive abnormality including one study that found a four-fold increase in mental retardation.[35]

Such disabilities will be expensive for society to cope with and it is likely that Medicaid will shoulder major expenses particularly for those individuals that will need long-term care for an extended portion of their lives.

Middle-class Americans with private health insurance policies will be affected in one other way if a sizeable portion of the adults and children now on Medicaid lose eligibility. The Affordable Care Act is expected to bring the number of Americans who have no health insurance from the current level of 50 million to below 20 million. But if as a result of the Ryan proposal we failed to not only extend coverage to those individuals but withdrew eligibility for Medicaid coverage for a substantial portion of nonelderly, nondisabled adults, the number of uninsured would spike from the current 50 million to 70 million or more—that would mean at least one American in five would be without health insurance.

Where does that figure come from?

If the Affordable Care Act is repealed, as Rep. Ryan is proposing, then the child and adult categories of Medicaid beneficiaries will total 54 million and the cost of providing benefits to them will be $260 billion. If legislatures look to this portion of the Medicaid budget to close half of the $200 billion gap discussed in the previous section, they would have to withdraw eligibility from 38 percent of the recipients in these two groups. That would total about 22 million.[36]

The problem for those who are insured and expect to be six years from now is that just because Medicaid eligibility is withdrawn does not mean that these 22 million people won't continue to get sick, have babies, and need care. A study several years ago by the American Medical Association found that in 2001 physicians in the United States lost more than $4 billion in revenue from providing unreimbursed care. Emergency room doctors were hit hardest, with 30 percent of them providing more than 30 hours of unreimbursed care per week.[37] Hospitals are also affected. The American Hospital Association estimates that in 2007 hospitals provided $31 billion in uncompensated care equal to about 6 percent of total hospital revenues.[38]

Of course doctors and hospitals must make up for lost income some place and while Medicaid and Medicare make a contribution, private insurers also must pay more and those charges are passed on to policyholders. The reduction in eligibility outlined above would increase the number of uninsured in the United States by 40 percent and greatly exacerbate the already strong tensions that this problem has created between health care providers, insurers, and they patients they serve.

But beyond cost, policyholders are affected in another way. Emergency rooms across the country are swamped by uninsured individuals who have come to use emergency rooms as a form of primary care because they have little alternative. This is not only an extremely expensive and wasteful means of providing care but it clogs vital facilities so they are not as available to those facing true medical emergencies as they should be.

In the end it is far more difficult to cut spending for children and nonelderly and nondisabled adults than it might first appear. It would be remarkable, for instance, for state legislatures that through the years have been more preoccupied with whether Medicaid funds could be used in performing abortions than any other aspect of the program to now slash funds necessary to insure that low-income women have the medical care necessary to carry their pregnancies to term and birth healthy children. Such cuts raise very troubling moral questions and legislatures—including those dominated by social conservatives—are not likely to want to accept responsibility for the consequences of such deep cuts in such programs.

As a result a very significant portion of the needed savings may have to come from Medicaid coverage provided to the elderly and disabled.

Understanding Medicaid assistance to the elderly

According to the Census Bureau, the federal poverty rate for the nation's elderly is 40 percent lower than the rate for nonelderly Americans (8.9 percent for persons over 65 in 2009 compared to 15.1 percent for those under 65).[39] In addition, nearly all elderly have health insurance coverage through Medicare.

Based on those two facts you might expect the demand for Medicaid services by senior citizens would be modest. In fact, Medicaid spends about 67 percent more on a per capita on the elderly population than on the nonelderly.[40]

The principle reason is long-term care and in particular nursing home care. In total about 33 percent of Medicaid spending goes for long-term care.[41] Nearly 70 percent of individuals turning 65 will at some point in their life require a period of long-term care. And 35 percent will eventually require nursing home care.[42] Medicare pays for 20 days of nursing home care and a portion of the cost for an additional 80 days. After that nursing home residents must turn to long-term health insurance or personal savings or Medicaid.

According to the Met Life Corporation, which conducts an annual survey of nursing home costs, the national average rate in 2010 for a private room "increased by 4.6 percent, from $219 daily or $79,935 annually in 2009, to $229 daily or $83,585. National average rates for a semi-private room increased by 3.5 percent, from $198 daily or $72,270 annually in 2009 to $205 daily or $74,825 annually in 2010." Average daily costs for a semi-private room ranged from $131 in Louisiana to $345 in Connecticut and $610 in Alaska.[43]

But even in the lowest cost states, the savings of all but the most well-to-do seniors are depleted quickly. The Federal Reserve Survey of Consumer Finances for 2009 indicates that the net worth of the median elderly household was about $200,000.[44] Most of that net worth was home equity with the median net worth in financial assets being less than $45,000.[45]

An analysis performed for the Kaiser Commission on Medicaid and the Uninsured found that 65 percent of elderly households did not have sufficient assets to cover a one-year stay in a nursing home and another 16 percent did not have sufficient assets to cover a three-year stay. Fewer than one in five elderly households had assets sufficient to cover more than three years of nursing home expenses. [46]

Even for an elderly couple with a net worth twice or three times the national median, an extended stay in a nursing home would have a catastrophic impact on family finances. As a 2007 report from the Urban Institute concluded, "Few people have insurance coverage against the high costs of long-term care. After impoverishing themselves, most people must turn to Medicaid, a means-tested welfare program, to pay for their long-term care services."[47] Another study of nursing homes by the Kaiser Foundation found:

> *Families view Medicaid as a last resort after personal resources are depleted. Even seemingly large savings do not go far in paying for long-term care services. While some families we interviewed had very limited income and assets, others*

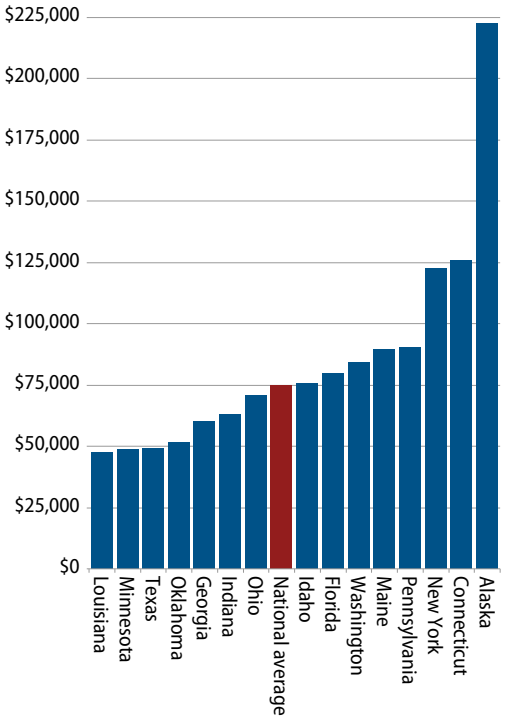
had nest eggs from retirement accounts, inheritance and house sales. Faced with medical expenses, drug bills, the cost of retrofitting homes to accommodate declining health and monthly bills for at-home care or assisted living, these sums are quickly depleted. It is a relief to families to know they can rely on Medicaid to pay for long-term care when their own resources run out.

The amounts families spend out-of-pocket can be staggering. Over the course of four years, Emily and John in Georgia spent over $165,000 on in-home care, nursing home services and prescription drug costs while Robert and Marian in Virginia spent about $40,000 on assisted living expenses. Even though these assets are exempt, Pearl sold her farm in Kansas and used these resources to pay forcare.[48]

FIGURE 7

Average annual cost of a semiprivate nursing home room by state

Metlife 2010 Market Survey of Long Term Care Costs



In response to the steady rise in elderly bankruptcies due to the increasing costs of long-term care, Congress amended the original Medicaid Act in 1988 to protect the assets of spouses of nursing home patients. Previously all of the assets (including home equity) held by a married couple had to be depleted in order for the one in need of nursing home care to qualify for Medicaid coverage.

The Medicare Catastrophic Coverage Act (which among other things) included what became known as the "spousal impoverishment" amendment to the original Medicaid legislation. This exempted a certain level of assets and income of a married couple from being included in the Medicaid impoverishment calculations so that the spouse not living in the nursing home would have an adequate amount to live on. Currently a couple can protect half of their assets (up to $109,560) and half of their income (up to $1822)[49] to cover the needs of the spouse who is not in the nursing home. By block granting Medicaid the Ryan proposal would repeal spousal imporverisment protection.

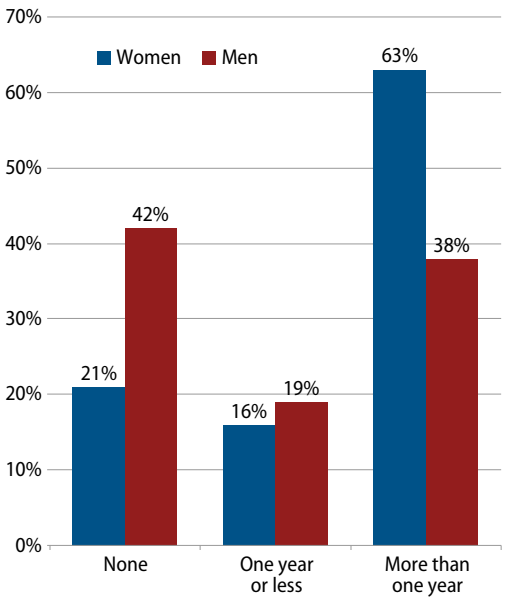
While Medicaid accounts for less than half of all nursing home payments it supports a much higher proportion of all nursing home patients since Medicaid pays significantly less per bed than is paid by private insurers or from out of pocket expenses. Data collected in the 2004 National Nursing Home Survey by the Centers for Disease Control indicate that there were 1,492,000 nursing home

residents at the time of the survey. Of the total, 35 percent were Medicaid beneficiaries at the time they were admitted to the facility in which they currently resided and an additional 25 percent had become beneficiaries by the time the interview took place.[50]

The Kaiser Commission on Medicaid and the Uninsured estimates that 70 percent of nursing home residents eventually become Medicaid beneficiaries.[51] A significant portion of the 35 percent of nursing home residents who initially qualify for Medicaid do so after spending some period of time in a home or other assisted care, having depleted their personal resources before they arrived. (See Figure 8)

FIGURE 8

How many 65-year-olds will need long-term care?



It is important to note that Medicaid benefits paid to nursing home residents impact the lives and well-being of individuals other than the recipient of the benefits.

At an earlier point in our history, the vast majority of frail elderly persons were cared for in the home. But a number of things have changed since that period. Families have fewer children and as a consequence fewer potential care providers. Further, adult daughters are no longer expected to stay home and give up their prospects of a career or marriage in order to care for an ailing parent or grandparent, which was sometimes true in the past. In addition, wives are now largely employed outside the home and have far less capacity to serve as caregivers. Finally the extended life of the elderly means that there are many more to be cared for; the period during which they are dependent on care is much longer and the level of care they need is higher.

Reverting to a system in which the government reduced or eliminated its commitment to paying for the nursing care of those who could not afford to pay for it from their own resources would shift a heavy burden onto many younger families to either provide the care themselves through adding a room on the back of the house (as was commonly done prior the passage of Medicaid in 1965) or diverting financial resources from other family needs, including home purchase, college education, and retirement.

This is not a problem that will affect all families since (as the above statistics demonstrate) two-thirds of all elderly persons don't require nursing home care

and among those who do, the stays are frequently short enough that the costs can be absorbed through the senior citizens' personal savings.[52] But in the absence of Medicaid, all but the wealthiest households are vulnerable to the possibility that an elderly parent will need an extended period of long-term care that will not only wipe out the resources of that parent but have a catastrophic impact on the finances of the younger family, which will feel obliged to do whatever is necessary to see that their parents are cared for.

Even though nursing home care is required by only a portion of the elderly, a middle-aged couple may have up to four living parents approaching the age of retirement. The chances that one of them will need long-term care is significant, and the notion that the government would reduce or eliminate their current level of commitment to insure that those needing long-term care will receive it will make financial planning and meeting other responsibilities infinitely more difficult.

It is also true that the elderly spouses of nursing home residents are greatly helped by Medicaid benefits and in particular the amended version of the law that enables them to protect enough income and saving to continue life with a modest living standard despite the costs related to their spouse's illness or disability.

Medicaid coverage for the disabled

Only one in six Medicaid beneficiaries qualifies for benefits on the grounds of disability, yet disabled Americans account for 45 percent of all Medicaid payments, with $184 billion spent on them last year or more than twice as much as for any of the three other recipient groups.[53] Further, it appears that a relatively small portion of this group accounts for a very large share of the costs. A 1996 study conducted for the Department of Health and Human Services by at team of researchers at Johns Hopkins University found that among children with disabilities who were Medicaid beneficiaries, 70 percent of the costs were attributable to only 10 percent of the children.[54]

The information that has been compiled on Medicaid beneficiaries with disabilities is surprisingly limited with respect to the types of disabilities they posses, the level of care they require, and the cost of that care. A 2002 study of disabled Medicaid beneficiaries in New York City and Westchester County, New York found that 36 percent had physical disabilities, 35 percent suffered from Mental Retardation, and 29 percent from mental illness.[55]

An article published in *American Family Physician* in 2000 estimated that "mental retardation" (which is now more frequently and appropriately referred to as intellectual disability) "is present in 2 to 3 percent of the population"[56] It is caused by a wide range of factors including genetic issues, low birth weight, and infectious disease. The most common cause is Downs syndrome. Of the approximately 4.5 million children who will be born in the United States this year, approximately 90,000 to 135,000 will eventually be identified as retarded, which is generally defined as a score of less than 70 on a standard IQ test.

Of those individuals, however, about 85 percent will have only mild retardation (generally defined as an IQ score between 50 and 75) and with sufficient family and community support may be capable of reasonably independent and possibly self-supporting life. Another 5 percent to 10 percent have moderate retardation and are capable of only simple communication skills and elementary health and safety habits.

About 4 percent have severe retardation with IQ scores between 25 and 35. These individuals are largely incapable of speech and may or may not become capable of very basic self-care. In some instances they may be capable of living in a group home but more frequently require more structure and supervision. Finally 1 to 2 percent are profoundly retarded and are incapable of language, self-care and, are often incontinent.[57]

The number of severely retarded and profoundly retarded children born each year is probably in the range of 6,000 to 10,000. These individuals require an extraordinary amount of care that rarely can be provided in a family setting. The cost of institutional care for these individuals can easily equal or exceed the cost of nursing homes for the elderly and those costs are well beyond the means of all but the most unusual young families.

Three or four decades ago, a large proportion of mentally retarded citizens were housed in large state run institutions. Medicaid has helped to move substantial numbers of those individuals out of such institutions and into less restrictive environments improving the lives of the beneficiaries and saving tax dollars at the same time. But there is little choice but to provide institutional care for those who cannot be supported in a community environment and that cost of that care is similar to that of the nursing home care required by the elderly—$80,000 a year. Since few families can afford that, Medicaid will continue to be the payer of last resort.[58]

Physical disabilities

Most Americans have health insurance that covers catastrophic illness and injury, but in most instances that insurance is tied to their employment. If they suffer a long-lasting injury or an illness that persists, they are unlikely to be able to hold the job that provides health coverage. Even if they can find alternate coverage (which given their health situation would be unlikely), they would quite likely no longer have the resources to pay the health insurance premium. If they can demonstrate to the Social Security Administration that they are sufficiently disabled to qualify for Social Security Disability Insurance they will also qualify for Medicare.

It is important to note, however, that one must have worked and paid Social Security taxes for 20 quarters or the equivalent of five years over the course of the previous 10 years. This leaves millions of adults without the prospect of Social Security Disability Insurance or Medicare coverage in the event of a catastrophic illness or injury.[59] This would include students, younger workers who have yet to work 20 quarters, full-time homemakers, and middle-aged individuals with extended periods of unemployment.

Even those who qualify for Social Security Disability Insurance and Medicare may have their financial resources so depleted by the time of qualification that they cannot support themselves on the level of benefits they will receive or afford the copayment necessary to maintain Medicare coverage. Furthermore, just as Medicare does not cover long-term care expenses for those over 65 it also does not provide such coverage for disabled beneficiaries under 65.

As a result, there are tens of millions of Americans today who would be forced to rely on Medicaid in the event they were the victim of a serious accident or a catastrophic illness.

According to the National Spinal Cord Injury Information Center at the University of Alabama, Birmingham, 250,000 Americans are currently living with spinal cord injuries. Spinal cord injuries afflict about 12,000 new victims each year. About half of those suffering spinal cord injuries are quadriplegics and the other half paraplegics. As might be expected, the largest cause is from motor vehicle accidents but falls account for 27 percent, violence 15 percent, and sports injuries 8 percent.[60]

Unlike many disabling injuries and illnesses, spinal cord injury victims are often young and unlikely to qualify for Social Security Disability or Medicare. A majority

of victims are employed at the time of their injury but only 10 percent are employed a year afterward. Average first-year medical and living costs range from $320,000 for the least severe cases to $985,000 for the most severe. Medical and living costs for a quadriplegic in the years following the injury average about $140,000.[61]

Obviously few people could bear that burden even if they were able to keep their job. Medicaid is for many the only means of obtaining the services needed to keep them alive.

While strokes are most common among the elderly, they are also a major disabler of non-elderly adults. According to the Centers for Disease Control, about 800,000 Americans below the age of 44 have experienced a stroke, and nearly 2 million between the ages of 44 and 64 have experienced a stroke. The National Institute of Neurological Disease and Stroke estimates that 10 percent of stroke victims require nursing home or other long-term care, and 40 percent experience moderate to severe impairments requiring special care.

The list of diseases that can result in severe disability making it impossible to engage in gainful activity is lengthy. It includes numerous forms of cancer, Parkinson's disease, multiple sclerosis, Alzheimer's disease, lupus, muscular dystrophy, Lou Gehrig's disease, HIV, and heart disease to name a few.

The National Institute of Mental Health estimates that more than 4 percent of Americans suffer from serious mental illness.[62] Many of these people can become a serious threat to themselves and others in the absence of effective treatment. Because severe mental illness frequently results in the inability of an individual to hold employment or maintain relationships with friends or family, a very large percentage of the mentally ill also become impoverished and large numbers end up in in state- and local-sponsored institutions. This has been the case since long before the Medicaid program was created.

The advent and use of more effective antidepressant and antipsychotic drugs over the past half century has greatly altered the care given to those who suffer mental illness, allowing state and local governments to significantly reduce the cost of such care. Medicaid has increasingly assumed the burden, paying for the medical personnel who prescribe these medications as well as the cost of the medications themselves. Medicaid has also been billed increasingly for the inpatient services required for those in this population who for periods of time need institutional care.

The data sited earlier from a study of New York beneficiaries who qualified by virtue of being disabled found that 29 percent of such beneficiaries qualified because of mental illness—somewhat smaller than the portion of disabled beneficiaries who were either mentally retarded or had physical disabilities.[63] If the New York number is a valid indicator of Medicaid beneficiaries nationally then it would mean that about 3 million people receive Medicaid benefits as the result of having a mental illness disability. That would be about one-third of the estimated number of severely mentally ill.

According to a 2005 analysis by the Department of Health and Human Services, Medicaid now pays about 28 percent of the medical costs related to mental illness. In 2005, that amounted to about $30 billion a year. It should be noted, however, that those who qualify for Medicaid based on disability due to their mental health do not account for all of the mental health billing.

Conclusion

The dramatic changes proposed in the 46-year-old Medicaid program by Rep. Ryan and House Republicans sparked less attention and controversy than one might expect for a proposal of this magnitude for several reasons. One is that they were proposed simultaneously with changes in Medicare that were equally sweeping but more easily understood. Second, while most people expect that they will someday need Medicare, they are less aware of the significant possibility that they or a member of their family may need Medicaid.

Third, because of the fact that final decisions about Medicaid coverage are made at the state level, it is difficult to predict how the states will respond to declining federal support and which beneficiaries will be impacted. Finally, decisions that legislatures make will vary from state to state with the outcome being quite different in some states than in others.

This paper attempted to quantify the magnitude of the shortfall state legislatures would be forced to contend with and the various options available to them in meeting those short falls.

In short, reasonable—perhaps even overly optimistic—assumptions about economic growth, inflation, and growth in state revenues indicate the gap between the cost of continuing current Medicaid eligibility and services and the revenues that states are likely to have available will be huge. The options for closing that gap will be excruciatingly painful.

It is likely that many states will attempt to reduce other state services, such as education, law enforcement, and highway construction, in order to reduce the number of currently eligible beneficiaries who would need to be excluded from Medicaid coverage. It is possible that some states will increase taxes to avoid eligibility and service reductions. But even with such measures it will be extremely difficult to avoid cuts in both eligibility and service.

While some might predict that eligibility for lower-income adults who are neither elderly nor disabled would be the easiest target for such cuts, those individuals as a group account for only 14 percent of overall Medicaid spending and a large majority of that may be the most cost-effective expenditures made by government in this country at any level—prenatal and maternity care. Legislators who wish to avoid being blamed for dramatic increases in the loss of unborn life as well as a spike in the birth of disabled and retarded infants may wish to avoid such cuts, leaving only nonmaternal adult medical services on the table—a tiny fraction of the total Medicaid budget.

That leaves three targets: children, disabled people, and the elderly. Children currently make up half of all Medicaid beneficiaries but only one-fifth of total Medicaid costs. If the states collectively faced a $200 billion gap between available revenues and the amount needed to continue current levels of eligibility and services in Medicaid, as this paper suggests (not including those added by the new healthcare reform legislation), then a 50 percent cut in eligibility that would eliminate coverage for 16 million children would only provide enough savings to reduce the gap by about a third. That makes it nearly impossible to avoid cuts in medical and long-term care for the elderly and disabled.

Doing that has significant implications for a broad spectrum of families and voters. If Congress is setting in motion a series of decisions that will make younger families responsible for the long-term care of grandparents after savings for medical and nursing home costs have been exhausted, then those families have a right to know that such responsibilities will be shifted to them now rather than after the decision to force such a choice has been completed.

By the same token, young couples planning to have families should know that if a pregnancy ends in the birth of a severely retarded child then the Medicaid support that has always been available from states in dealing with such responsibilities may not still be there. And if it is not going to be there, then giving it up was supposedly the best of a number of hard choices, including the closing of tax loopholes and forgoing further tax cuts to the nation's highest earners.

Make no mistake, there are some savings in this or any program that can be made without reducing services. There are providers who submit false or erroneous claims. There are certain medical issues that can be addressed effectively with lower cost procedures or treatments than Medicaid in many states now pays for.

There are ways to improve the quality of diagnosis and care so repeated visits and the charges associated with those visits can be eliminated. There are ways to improve the efficiency with which states administer the Medicaid program and lower overhead costs.

Medicaid should not be exempt from such scrutiny.

But these savings are likely to be smaller in Medicaid than in most other programs because Medicaid is already the lowest cost payer and has been subjected to intense annual scrutiny for decades by nearly legislature in the country. That reality means that cuts of the magnitude Rep. Ryan and his fellow House Republicans are proposing will come from the muscle rather than the fat of this program

If that is what Congress has in mind, they should come forward with the truth now rather than after these policies have been crammed into must-pass legislation in late-night, closed-door negotiations.

Appendix A

The table on page 32 is a reproduction of the "supplemental data" provided by the Congressional Budget Office on March 18, 2011, which details the assumptions used by CBO in creating the March 2011 baseline for Medicaid spending between now and 2012. These assumptions were used as much as possible in preparing the data and projections contained in this report.

Those assumptions anticipate that the expansion of Medicaid eligibility contained in the Affordable Care Act will be implemented, whereas Rep. Ryan's proposal assumes that legislation will be repealed. Consequently, a number of adjustments to the CBO data were necessary for the analysis of Rep. Ryan's plan contained in this report. These changes include:

- Reductions in the number of children and adults that will be enrolled in Medicaid in 2021
- The per patient cost of adults in 2021 (CBO expects that those who will be made eligible under the provisions of ACA will be older, sicker, and more costly than those who are currently enrolled)
- The total cost to the federal government of providing coverage to those two groups in 2021

Those changes are presented in the table below.

Spending and enrollment detail for CBO's March 2011 baseline: Medicaid

Fiscal year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Average annual rate of growth 2011-16	Average annual rate of growth 2011-21
Federal Medicaid payments (outlays in billions of dollars)[1]														
Benefits														
Acute care														
Fee-for-service	102.6	102.3	92.5	100.6	128.5	150.4	171.9	184.7	196.2	209.5	222.6	238.5	11%	9%
Managed care	61.1	62.7	60.3	62.9	73.9	83.9	93.8	100.8	107.7	115.2	122.7	131.4	8%	8%
Medicare premiums	7.7	8.5	8.6	7.9	8.2	8.7	9.2	9.9	10.6	11.3	12.1	13.0	2%	4%
Long-term care	79.0	79.0	74.4	78.5	84.1	89.9	96.3	103.1	110.7	119.0	127.7	137.3	4%	6%
Subtotal	**250.4**	**252.5**	**235.8**	**249.9**	**294.6**	**332.8**	**371.3**	**398.5**	**425.1**	**455.1**	**485.2**	**520.2**	**8%**	**7%**
Disproportionate Share Hospital	8.7	8.1	8.6	8.9	8.5	8.6	8.9	7.9	5.0	4.7	6.7	11.0	2%	3%
Vaccines for Children	3.7	4.0	4.2	4.4	4.8	5.1	5.5	5.8	6.2	6.6	7.0	7.5	6%	7%
Administration	10.0	10.4	11.0	11.7	14.3	14.7	15.9	16.5	17.5	18.8	20.0	21.1	9%	7%
Total	**272.8**	**275.0**	**259.7**	**274.9**	**322.1**	**361.2**	**401.5**	**428.8**	**453.9**	**485.2**	**518.8**	**559.9**	**8%**	**7%**
Percentage change in federal Medicaid payments														
Benefits														
Acute care														
Fee-for-service	0%	-10%	9%	28%	17%	14%	7%	6%	7%	6%	7%			
Managed care	3%	-4%	4%	17%	13%	12%	8%	7%	7%	7%	7%			
Medicare premiums	11%	1%	-8%	4%	6%	7%	7%	7%	7%	7%	7%			
Long-term care	0%	-6%	6%	7%	7%	7%	7%	7%	8%	7%	8%			
Subtotal	1%	-7%	6%	18%	13%	12%	7%	7%	7%	7%	7%			
Disproportionate Share Hospital	-7%	6%	3%	-4%	2%	3%	-11%	-37%	-6%	41%	65%			
Vaccines for Children	7%	6%	5%	8%	6%	7%	7%	7%	7%	7%	7%			
Administration	4%	5%	6%	22%	3%	9%	4%	6%	7%	6%	6%			
Total	**1%**	**-6%**	**6%**	**17%**	**12%**	**11%**	**7%**	**6%**	**7%**	**7%**	**8%**			
Federal benefit payments by eligibility category (outlays in billions of dollars)														
Aged	51.9	51.3	48.0	50.3	53.6	57.2	61.3	65.9	70.9	76.5	82.3	88.7	4%	6%
Blind and disabled	107.5	109.9	105.1	114.7	123.2	130.6	138.8	147.5	157.0	167.1	178.0	189.6	5%	6%
Children	55.0	55.3	50.1	51.5	56.0	60.2	65.0	69.5	74.0	79.5	85.1	91.3	3%	5%
Adults	36.1	36.0	32.6	33.3	61.7	84.9	106.2	115.6	123.2	132.0	139.8	150.6	24%	15%
Total	**250.4**	**252.5**	**235.8**	**249.9**	**294.6**	**332.8**	**371.3**	**398.5**	**425.1**	**455.1**	**485.2**	**520.2**	**8%**	**7%**
Enrollment by eligibility category (millions of people)[2]														
Aged	5.5	5.5	5.5	5.6	5.6	5.7	5.8	5.9	6.1	6.2	6.3	6.5	1%	2%
Blind and disabled	10.4	10.8	11.2	11.4	11.6	11.6	11.6	11.7	11.7	11.7	11.7	11.8	1%	1%
Children	33.5	34.3	34.4	33.5	35.5	35.9	36.8	37.2	37.6	38.1	38.5	39.1	1%	1%
Adults	18.3	18.9	18.9	18.3	26.5	30.4	34.8	35.4	36.0	36.6	37.1	37.8	13%	7%
Total	**67.7**	**69.5**	**70.0**	**68.7**	**79.2**	**83.7**	**89.1**	**90.1**	**91.3**	**92.6**	**93.7**	**95.1**	**5%**	**3%**
Average monthly enrollment	**54.8**	**56.3**	**56.8**	**55.9**	**63.7**	**67.0**	**71.0**	**71.9**	**72.8**	**73.8**	**74.7**	**75.7**	**5%**	**3%**
Average federal spending on benefit payments per enrollee[3]														
Aged	$13,028	$12,893	$11,948	$12,394	$13,028	$13,676	$14,419	$15,202	$16,039	$16,943	$17,861	$18,820	2%	4%
Blind and disabled	$11,044	$10,884	$10,095	$10,778	$11,438	$12,057	$12,782	$13,560	$14,402	$15,297	$16,257	$17,270	3%	5%
Children	$1,684	$1,654	$1,492	$1,583	$1,624	$1,724	$1,815	$1,926	$2,027	$2,138	$2,269	$2,400	2%	4%
Adults	$2,140	$2,066	$1,863	$1,981	$2,502	$3,003	$3,280	$3,514	$3,674	$3,876	$4,046	$4,291	10%	8%

1 The American Recovery and Reinvestment Act of 2009 provides states with additional federal financial assistance through December 2010. Subsequent legislation (P.L. 111-226) continued enhanced matching rates for an additional six months leading to an average rate of about 64 percent in FY 2011. On average from FY 2012 to FY 2013, federal Medicaid payments represent approximately 57 percent of total Medicaid payments. The Patient Protection and Affordable Care Act, which expands Medicaid coverage starting in 2014, provides enhanced federal matching rates for certain populations, leading to an average federal share for Medicaid ranging between 60 percent and 62 percent, depending on the year.

2 These figures are the total number of individuals enrolled in Medicaid at any point during the fiscal year and include enrollment in the territories. Some beneficiaries are enrolled for only part of the year; enrollment on an average monthly basis, as shown in the memo line, would be about 80 percent of these figures.

3 These figures are based on the annual cost of enrollees who receive the full Medicaid benefit package and exclude those who receive only partial Medicaid benefits, such as family planning services or assistance with Medicare cost sharing and premiums.

Appendix B

This table on page 34 below is constructed largely from the Congressional Budget Office estimates contained in Appendix A. In addition, it provides an estimate of the total Medicaid spending level (assuming that the CBO estimate of the federal share will equal 57 percent of the total and the state share will equal 43 percent). In addition, this table provides an estimate of the number of enrollees in the Medicaid program in 2021 if the Affordable Care Act is repealed as Rep. Ryan proposes and the current eligibility levels are continued. These estimates are based on the following assumptions:

- The number of enrollees in the categories "children" and "adults" will grow at the same rate as the overall population (1 percent per year)
- The number of enrollees projected by CBO to be in the categories "elderly" and "blind and disabled" will not be affected by the repeal of the Affordable Care Act
- The cost per enrollee for adults increases by 70 percent or roughly in line with the increased cost per enrollee for the other three categories of enrollees rather than the 130 percent increased enrollment cost used by CBO in estimating cost per enrollee assuming the expanded eligibility under the Affordable Care Act
- The federal payment to states under the Ryan proposal will increase based on CBO projections for inflation and U.S. Census Bureau projections of population growth
- That state contributions under the Ryan proposal in 2021 be expressed in terms of current state contributions in order to express the nominal increase in state contributions that will be necessary to maintain current eligibility and service levels

See table below for details.

CBO projection of Medicaid costs by beneficiary group

	Federal Medicaid payments 2012	State Medicaid payments 2012	Total Medicaid payments 2012	Federal Medicaid payments 2021	State Medicaid payments 2021	Total Medicaid payments 2021
Elderly	$48.0	$36.2	$84.2	$88.7	$66.9	$155.6
Blind and Disabled	$105.1	$79.3	$184.4	$189.6	$143.0	$332.6
Children	$50.1	$37.8	$87.9	$91.3	$68.9	$160.2
Children w/o Affordable Care Act	$50.1	$37.8	$87.9	$87.1	$65.6	$152.7
Adults	$32.6	$24.6	$57.2	$150.6	$113.6	$264.2
Adults w/o Affordable Care Act	$32.6	$24.6	$57.2	$62.7	$47.3	$110.0
Children and adults w/o Affordable Care Act	$82.7	$62.4	$145.1	$149.8	$112.9	$262.7
Total with Affordable Care Act	**$285.9**	**$215.7**	**$501.6**	**$607.3**	**$458.0**	**$1,065.3**
Total w/o Affordable Care Act	**$235.8**	**$177.9**	**$413.7**	**$428.1**	**$322.8**	**$750.9**
Ryan block grant proposal						
Elderly	$48.0	$36.2	$84.2	$62.4	$36.2	$98.6
Blind and disabled	$105.1	$79.3	$184.4	$136.6	$79.3	$215.9
Children w/o Affordable Care Act	$50.1	$37.8	$87.9	$65.1	$37.8	$102.9
NEND Adults w/o Affordable Care Act	$32.6	$24.6	$57.2	$42.4	$24.6	$67.0
Children and adults w/o Affordable Care Act	$82.7	$62.4	$145.1	$107.5	$62.4	$169.9
	$235.8	$177.9	$413.7	$306.5	$177.9	$484.4
				70.74		
Shortfall in funding required to maintain current service levels						
Elderly	-	-	-	$26.3	$30.7	$57.0
Blind and disabled	-	-	-	$53.0	$63.7	$116.7
Children w/o Affordable Care Act	-	-	-	$22.0	$27.8	$49.8
Adults w/o Affordable Care Act	-	-	-	$20.3	$22.7	$43.0
Children and adults w/o Affordable Care Act	-	-	-	$42.3	$50.5	$92.8
Shortfall	**-**	**-**	**-**	**$121.6**	**$145.0**	**$266.5**

Endnotes

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13 Ibid.

14 See Appendix A.

15 See M William Sermons and Peter Witte, "State of Homelessness in America 2011" (Washington: National Alliance to End Homelessness, 2011). The report estimates that there were at any given point in time about 656,000 homeless in the United States in 2009. The Congressional Budget Office estimates that there are currently 10.8 million people receiving Medicaid benefits by virtue of being either blind or disabled. A 33 percent cut in those benefits could be expected to affect about 3.5 million people, some of whom are in institutions, group homes or other community facilities and others of whom need medications provided by Medicaid to sustain themselves in an independent environment.

16 Congressional Budget Office, "Supplemental Data on Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid."

17 This number is extrapolated from CBO estimates with two changes. First the number of child and adult beneficiaries is reduced to allow for the proposed repeal of PPACA. Secondly, the CBO estimate for the increase in per beneficiary coverage costs for nonelderly, nondisabled adults is reduced. The CBO estimate of a 101 percent increase over eight years appears to be based on the fact that PPACA will extend coverage to individuals that as a group are older and sicker than the current beneficiary pool. This analysis uses the 43 percent per beneficiary increase during the 8-year period that CBO has projected for children. See Appendix A.

18 A study on the effects of denying prenatal benefits to undocumented immigrants in California—Michael C. Lu and others, "Elimination of public funding of prenatal care for undocumented immigrants in California: A cost/benefit analysis," in *American Journal of Obstetrics and Gynecology* 182 (1) (2000): 233-239—found that women without prenatal care "were nearly 4 times as likely to be delivered of low birth weight infants." A 2009 Report by the March of Dimes foundation found that the average cost for delivery of a low weight baby was $49,000 or about 10 times the cost of a baby born without complications. Such babies are also at greater risk of numerous disabilities and low weight births are only one consequence of the lack of prenatal and maternity care.

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