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Medicaid's Status As An Open-Ended Entitlement Is On Life Support Following The Election

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Table Of Contents

Status Quo

Congressional Leaders Propose "A Better Way"

What We Are Watching For

Notes

Medicaid's Status As An Open-Ended Entitlement Is On Life Support Following The Election

Following the November election results, S&P Global Ratings believes the possibility for a significant overhaul to the Medicaid program has never been greater. At over $330 billion in fiscal 2016, Medicaid accounts for more than half of all federal grants to state and local governments, larger than any other program. Medicaid therefore sits at the heart of the federal-state fiscal relationship.

Medicaid also has been integral to the expansion of health insurance coverage under the Patient Protection and Affordable Care Act (ACA). Medicaid enrollments have added more than 15.7 million to the ranks of the insured since October 2013 when the ACA marketplace exchanges opened. Assuming the new administration's health care reform agenda includes making changes to the ACA and its expansion of Medicaid, as well as Medicaid's basic financing arrangements—and we believe it does—there is much at stake for the states and health care providers from a fiscal and a credit standpoint.

Overview

- Post-election, there's an increased likelihood of significant changes to both the ACA and Medicaid;
- Medicaid is both a health insurance program and a mechanism for delivering aid to states during recessions;
- The leading alternative to the existing federal-state arrangements is some form of block grants;
- Block grants could reduce Medicaid's role in providing countercyclical aid to states during recessions, exacerbating their effect on state finances;
- Block grants would likely reduce Medicaid reimbursement growth to less than medical inflation and thus hurt credit quality in the not-for-profit health care sector.

In each of the two most recent recessions, Medicaid provided a key channel for the delivery of billions of dollars in countercyclical federal fiscal aid. If health care reform eliminates that mechanism--for example, through establishing block grants in lieu of traditional entitlement funding--the next recession could force states to either limit medical insurance coverage or face large Medicaid-driven fiscal imbalances, which could be a Hobson's choice given their balanced budget requirements.

The election outcome has raised the likelihood that some type of significant reform of the ACA and Medicaid will receive serious consideration. Among the most prominent reform ideas are block-granting federal Medicaid funds and establishing per capita allotment caps in federal funding for Medicaid. Both would set initial grant amounts, either globally by state or on a per capita basis, likely based on existing federal Medicaid funding levels. In subsequent years, grant amounts would increase, though at a lower rate than Medicaid's current trajectory, thereby generating fiscal savings at the federal level. With federal funding capped, states would have incentive to constrain the growth of their Medicaid programs' expenditures, either through program efficiencies or by reducing coverage levels. Crucially, under the leading block grant proposals, federal funding each year is a fixed amount regardless of fluctuations in enrollments for economic reasons. For states, this could lead to more acute fiscal strain during recessions when falling incomes

correspond to increased enrollments.

One of the Trump campaign's frequently heard policy pronouncements was to "repeal and replace" the ACA. Many states used the ACA to expand Medicaid and this has generally been a benefit to health care credit quality in those states. While the repeal of the ACA would be detrimental to overall health care credit quality, much would depend on the nature of the replacement aspect of "repeal and replace." While we don't know exactly what the new administration will propose, such a policy is widely expected to curtail the ACA benefits to some extent. Given the role of Medicaid expansion in the ACA, any use of block grants would, in our view, likely contribute to weaker financial profiles for health care institutions.

Below, we consider some of the likely potential outcomes of efforts to reconstitute the Medicaid program. These include the preservation of the status quo, establishing per capita allotment caps, and block-granting the program. We also describe what we view as the potential credit upsides and downsides to states of each scenario, as well as some views on not-for-profit health care organizations.

Status Quo

It may seem unlikely, given the political alignment taking shape in Washington, but we cannot rule out the possibility that when it comes to Medicaid, lawmakers will opt to maintain the status quo. There are numerous reasons why a new presidential administration and the Congress could fail to reach agreement on revamping a 50-year old entitlement program even if, conceptually, they share a desire to do so.

What it looks like

Established in 1965, Medicaid is a health care entitlement program for qualifying low-income, elderly, and disabled people that is jointly financed by the federal and state governments. The states administer their Medicaid programs and are entitled to federal matching funds so long as they guarantee coverage to certain populations--primarily children, pregnant women, parents, elderly, disabled individuals, and, more recently, childless adults—all up to certain income thresholds. From an all-funds perspective, Medicaid is the states' single largest programmatic expenditure and the second largest general fund expense after elementary and secondary education. By virtue of Medicaid's status as a federal entitlement, since its inception states have been assured they will be reimbursed for eligible expenditures.

Outside of satisfying certain federal minimum requirements, states have considerable latitude over the design of their Medicaid programs. State Medicaid programs differ in a number of important ways, including rules governing eligibility (beyond the core required populations), which benefits are covered (beyond core requirements), and whether the state program is structured as a managed care, including capitation, or fee-for-service model. The federal government matches state expenditures according to a formula that provides a higher subsidy to states with lower per capita incomes relative to the national average, and vice versa. Historically, federal subsidy rates to the states ranged between 50% and 75%, averaging 57% across all the states. (Subsidy rates are range bound federal law to between 50% and 83%)

Beginning in 2014, states had the option under the ACA to extend coverage to childless adults—a group that traditionally was not eligible for Medicaid—with incomes of up to 138% of the federal poverty level (FPL). Unlike for

the previously eligible populations, the ACA provided states with a 100% federal match for the newly eligible population. To date, 31 states have adopted Medicaid expansion, broadening coverage to the childless adult population at the higher federal match rate. Consequently, the share of overall Medicaid spending paid for with federal funds increased to over 60% in 2014 and 2015 from 57% before the ACA took effect. In 2016, the federal subsidy rate for the newly eligible population stepped down to 95%. Under current law, the match rate is scheduled to continue tapering until 2020, at which point it will be 90% for the expansion population.

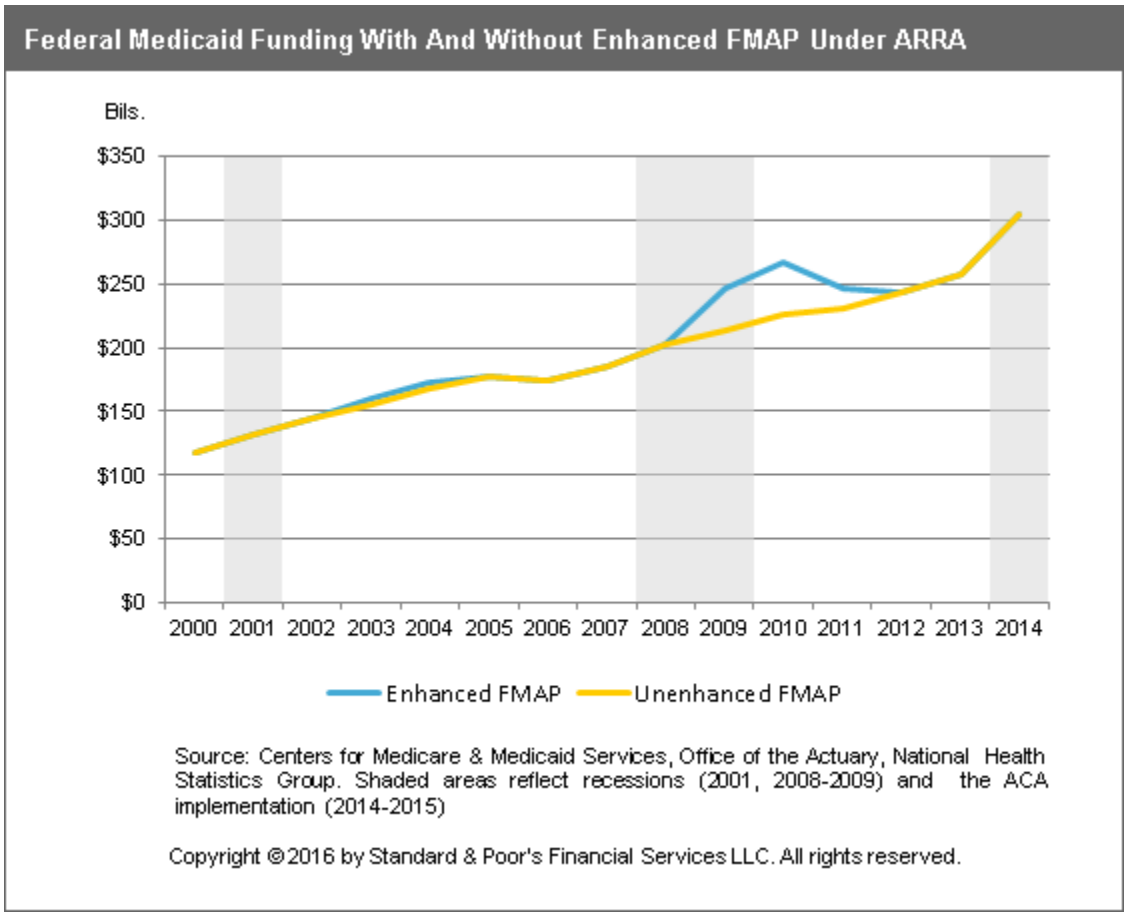
For many not-for-profit hospitals, the expanded Medicaid program provided meaningful improvement to their overall payor mixes and therefore profitability. In general the costs of caring for uninsured patients went down across the country, although this varied considerably by state and by individual hospitals, as millions of uninsured people got health insurance via Medicaid. While Medicaid is generally considered every hospital's weakest payor, it is better than the payment received from patients without insurance.

Credit upside of status quo

If it were to go unchanged, Medicaid would remain a key source of open-ended federal funding for a major means-tested health care program. The increased flow of federal funding to states that occurs when Medicaid enrollments inflate during economic downturns—as people lose jobs--softens the blow recessions have on state finances and economies. Federal spending on Medicaid is unconstrained by legal balanced budget requirements that govern the states. When recessions strike, federal spending on Medicaid typically increases—sometimes dramatically—despite the falling federal tax receipts. In this sense, Medicaid has functioned as one of the federal "automatic stabilizers"—increased aid to states and individuals triggered by a weakening economy, not requiring separate congressional or executive branch action. (Other automatic stabilizers include food stamps, temporary assistance programs, unemployment insurance, and even reduced federal tax liabilities resulting from falling incomes.)

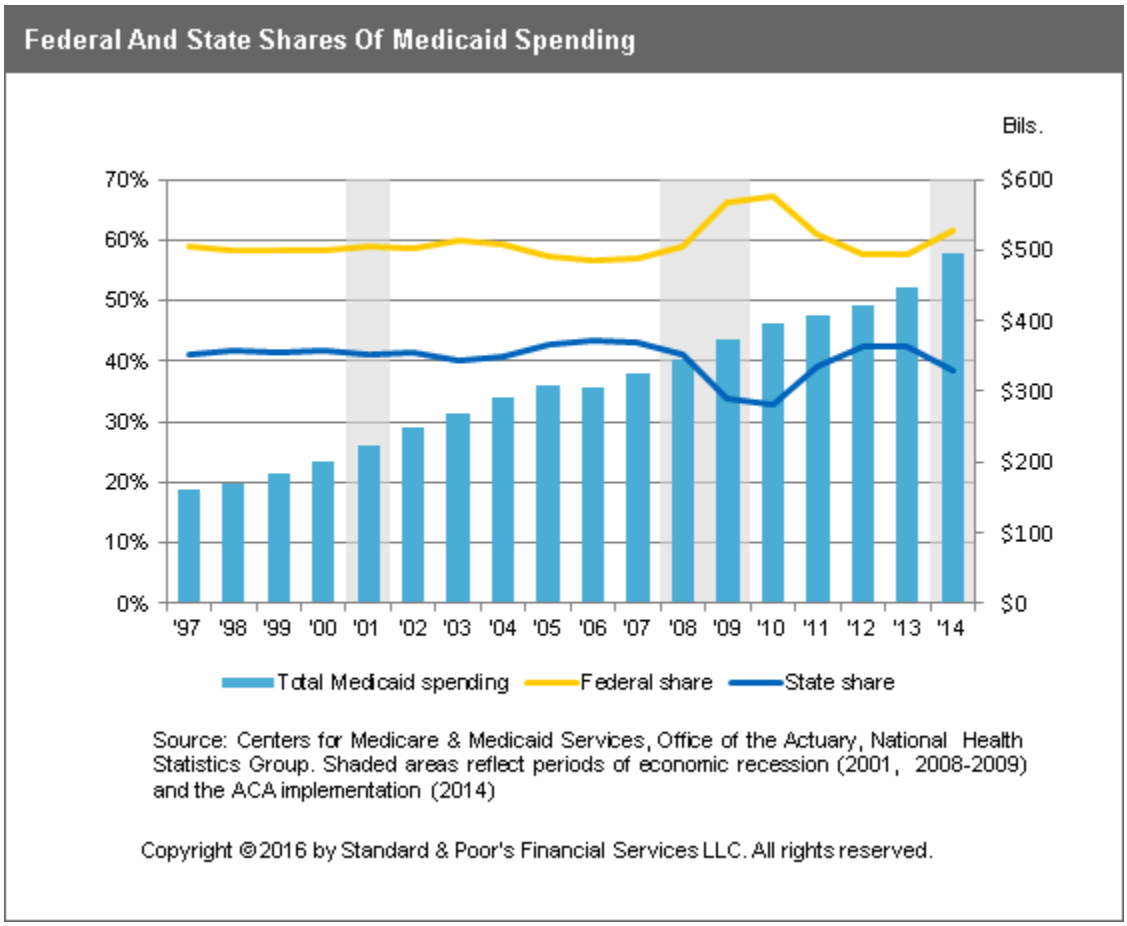
As the Great Recession unfolded, Medicaid enrollments began to ramp upward. After having been flat in 2006 and 2007, enrollments ticked up by 3.5% in 2008 and then surged 7.6% in 2009. Not surprisingly, Medicaid spending followed suit, increasing by 5.7% in 2008 and 8.8% in 2009. Federal funds covered virtually all of the cost increase, however, and largely insulated the states from the fiscal effects of rising enrollments. State spending on Medicaid grew by just 0.6% in 2008 whereas federal spending increased by 9.5%.

Chart 1



When Congress included fiscal aid to the states as part of the American Recovery and Reinvestment Act (ARRA), Medicaid served as a central artery for the delivery of the relief funding. Specifically, lawmakers approved a temporary enhancement to the federal medical assistance percentage—FMAP—which in the aggregate, elevated the subsidy rate to 67% from 57%. This allowed state spending on Medicaid to decline by 9.9% in fiscal 2009 even as total Medicaid spending spiraled upward by 8.8%.

Chart 2



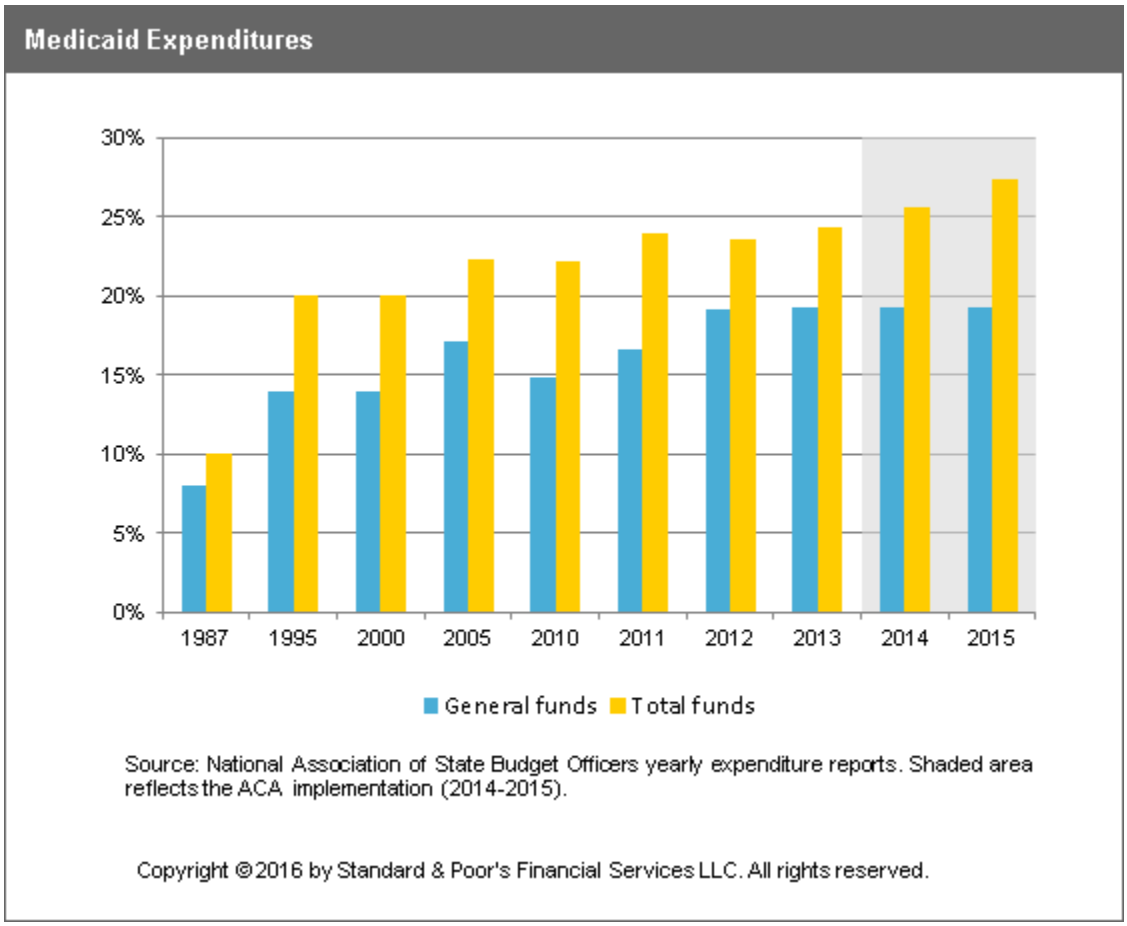
In our view, both the regular and extraordinary federal fiscal aid to states for Medicaid lessened the budgetary fallout on states of the recession. We have viewed this aspect of U.S. fiscal federalism as beneficial to state credit quality.

In a comparable way, the increase in Medicaid enrollment during this period, post the 2008 recession, helped many health care providers offset a potentially difficult rise in the number of people without health care insurance.

Credit downside of status quo

Putting aside which level of government pays for it, the growth rate of Medicaid expenditures—as with health care spending generally—has outpaced broader measures of inflation. From 2004 through 2014, total Medicaid expenditures increased by 71%. Although the federal government picked up the tab for much of the additional expense, the states' share of Medicaid costs also ballooned, increasing by 60%. Total spending from state general funds only increased by 40% during the same time, implying that Medicaid has crowded out other program areas. One example is higher education. From 2005 through 2015, the share of state general fund budgets going to higher education shrunk to 10% from 11.7% while Medicaid has increased to 19.3% from 17.1%(1). Therefore, notwithstanding that federal funds cover a significant portion of Medicaid's cost, even the smaller state share is on an unsustainable trajectory.

Chart 3



Furthermore, as it's currently designed, Medicaid incentivizes states to leverage federal aid by increasing their spending on Medicaid, thus exacerbating long-term fiscal imbalances at the federal level.

Congressional Leaders Propose "A Better Way"

In its "A Better Way" plan released in June 2016, the Republican caucus in the U.S. House of Representatives proposed ending Medicaid's open-ended entitlement structure in favor of a fixed-grant funding arrangement. According to the "A Better Way" plan, states would have the option to receive federal funding in the form of either a block grant or a per capita allotment.

Per capita allotment

What it looks like. Federal grants to states would be capped on a per-enrollee basis. After establishing a base year, possibly informed by existing per-enrollee federal spending in each state, grant amounts would grow by an adjustment factor and total enrollment. Alternatively, grant amounts could be set nationally. Either way, because a stated objective of the proposal is to achieve federal fiscal savings, the adjustment factor would almost certainly result in grant amounts growing more slowly than federal Medicaid funding under the current law and below medical cost inflation. It's also likely that the per capita grants would vary by eligibility group, resulting in larger grants for beneficiaries with higher costs (i.e. the aged and those with disabilities).

Credit upside. Allotment caps would be at the level of the enrollee, not the overall grant amount to each state. Therefore, in addition to the annual adjustment factor, total federal grants to states would fluctuate with each state's number of enrollees. From a fiscal and credit perspective, this would allow for federal grants to increase when enrollments go up because of an economic downturn, much as they do now. This could preserve some of Medicaid's capacity to partly counteract the effect of the business cycle on state finances.

Credit downside. There are difficult tradeoffs involved in establishing the base year grants for the per capita allotment approach. If federal spending per enrollee in each state were the basis, then existing disparities among the states and their Medicaid programs would be locked in. States that spend more lavishly per enrollee would receive larger grants while those with more austere programs would be in line for smaller ones. The alternative, providing a common per enrollee grant to all states, could be very disruptive from a policy perspective. According to the Kaiser Family Foundation, in 2011, Medicaid spending in some states exceeded $10,000 per enrollee and was less than $5,000 in others. A one-size-fits-all grant would require states with currently disparate programs to adjust, in some cases dramatically. States that currently spend relatively more per enrollee would be forced to scale down their programs or fund the difference with their own resources. Both methods of setting the per capita allotments—nationally or based on state spending per enrollee—could have unintended policy consequences, some of which could pressure state budgets. In addition, the cost of providing even the same basket of services varies across the country and a fixed reimbursement level across the country would favor some states at the expense of others. To the extent year-over-year increases to health care providers are below medical inflation, overall profitability and therefore credit quality could be expected to be pressured.

Block grants

What it looks like. In lieu of open-ended matching funds, states would receive lump sum payments from the federal government for their Medicaid programs. Most proposals involve an initial block grant sized to approximate what the states currently receive in federal funding. Block grants in subsequent years would increase according to a predetermined growth factor. As with per capita allotments, the growth factor would presumably place federal Medicaid spending and health care reimbursement on a lower trajectory than under the current law. In exchange, states presumably would have greater flexibility over the design and coverage levels of their programs. In our view there would be an increase in managed care programs that include capitation.

Credit upside. With additional flexibility, states may achieve increased programmatic efficiencies. Under current law, the ability of states to explore policy innovations is impeded by the need to obtain federal waivers, which can be administratively burdensome. It is possible that states could realize budgetary savings through the use of premiums, cost-sharing arrangements, work requirements, or health savings accounts—all of which are generally precluded under existing law.

Credit downside. Block grants would diminish Medicaid's role as an automatic stabilizer. The states would be more exposed to the full brunt of economic recessions if federal Medicaid funding were less—if at all—countercyclical, which it would be under in a block grant scenario. Thus one of Medicaid's attributes--its countercyclical fiscal support function--could be lost. Under such a model, the states could be exposed to greater recessionary variability and potentially greater ratings volatility. By having leveraged greater amounts of federal funding, the expansion states would be subject to even more economic dislocation if federal funds were capped than would the non-expansion states.

Similarly, health care providers generally experience operating pressure during times of recession as more people lose their health care insurance entirely or commercially insured people lose their insurance and qualify for Medicaid. In each of these scenarios, the inability of states to automatically increase their Medicaid expenditures as a result of the economic dislocation of their citizens would directly hurt credit quality in the health care sector depending on the

particulars of each hospital.

What We Are Watching For

Medicaid's impact on state finances is difficult to overstate given its large size and the countercyclical tendency of its cost drivers. The program has also functioned as a key instrument for the expansion of health insurance coverage under the ACA. Considering that key congressional leaders as well as President-elect Trump have consistently expressed their intent to repeal the health law, we believe Medicaid will come under significantly greater scrutiny. And, even without comprehensive reforms of the type we described above, lawmakers could opt to end the enhanced subsidies for states that have opted to expand their Medicaid programs under provisions of the ACA. In that scenario, the 31 expansion states would face the choice of cutting benefits for the expansion population or funding the coverage from their own resources, which could result in significant budgetary pressure, in addition to placing an additional stress onto health care providers and the individual Medicaid enrollees.

More broadly, we believe the key issue for state finances and credit quality will be whether Medicaid reforms would preserve the linkage between federal aid to states and enrollees. Under the existing law, federal Medicaid funding (as a mandatory federal expenditure and entitlement) is tied to enrollees and has emerged as a relatively reliable source of federal revenue for the states. If the linkage between funding and enrollees were severed, states would face a policy choice of whether to maintain benefits and coverage above federal funding caps (assuming the reforms also provided states with increased program flexibility). The policy tradeoffs would be starker both during economic downturns when enrollment—and Medicaid costs—increase and over time given the aging of the U.S. population. At 9% of Medicaid enrollees, elderly beneficiaries currently account for a disproportionate 18% of program expenditures. We anticipate this and the extent of policy flexibility granted to the states will be important factors in the effect any reforms will have on state credit quality. In addition to the potential impact on state quality from these types of changes, the overall direction of these changes would be to incrementally weaken Medicaid as a payor to health care providers.

Research assistance provided by Joshua Hanson

Notes

(1) National Association of State Budget Officers, "State Expenditure Report, Fiscal 2013-2015."

(2) Department of Health and Human Services, "2015 Actuarial Report On The Outlook For Medicaid."