kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

APRIL 2011

IMPLICATIONS OF A FEDERAL BLOCK GRANT FOR MEDICAID

As state and federal policymakers face budget shortfalls and recurrent budget deficits, proposals to lower Medicaid spending by converting the program into a block grant have re-emerged. The FY 2012 budget resolution released April 5, 2011 by the House Committee on the Budget includes an estimated savings of $1.4 trillion in Medicaid related to converting the program to a block grant and repealing health reform.[1] Such changes represent a fundamental change in the entitlement nature and financing structure of the program that would have major implications for beneficiaries, providers, states and localities. Such changes could also affect the ability of Medicaid to maintain its current roles in the health system.

Medicaid provides an entitlement to coverage for individuals eligible for the program. Currently, Medicaid covers low-income individuals who meet categorical and income standards including children and parents, individuals with diverse physical and mental conditions and disabilities, and seniors. The federal government sets minimum eligibility standards, and states may expand beyond these minimum levels. Under the entitlement, states cannot cap or close enrollment for individuals who meet eligibility standards for the program. This helps to ensure that coverage is available when unemployment rises and incomes fall during an economic downturn. Children, parents, individuals with disabilities and seniors on Medicaid tend to be poorer and sicker than low-income individuals with private insurance. Spending for high-need populations account for the majority of Medicaid spending. The elderly and disabled only account for one in four enrollees, but about two-thirds of Medicaid costs.

Medicaid also guarantees states to federal matching payments with no cap to meet program needs. The federal matching percentage (FMAP) is based on a formula in statute that provides relatively poorer states more federal assistance. The financing model allows federal funds to flow to the states based on actual needs, such as increased enrollment during an economic downturn. In exchange for receiving federal matching funds, states must meet minimum federal program rules. Beyond these federal minimums, states have a broad set of options to determine who is eligible, what benefits are covered, how care is delivered, and how and what providers are paid. As a result of this flexibility there is large variation across Medicaid programs.

The trade-off in achieving predictable and reduced levels of federal financing and deficit reduction through a Medicaid block grant would be the elimination of the entitlement to coverage and the guaranteed federal matching payments to states. Some federal proposals to reduce the federal deficit would convert all or part of Medicaid to a block grant. Under a block grant, Medicaid funding would not be responsive to changing program needs like recessions, health care inflation, epidemics, or disasters; it would be difficult to allocate funds equitably across states, and coverage would not be guaranteed. It is also unclear what state requirements would be in place to maintain accountability for federal dollars. While some argue that spending is too high, Medicaid spending growth on a per capita basis over the last decade was (4.6%) slower than the rate of growth in private insurance premiums (7.7%).

A block grant with greatly reduced levels of federal financing would not reduce underlying program costs but would shift costs and risk to states, localities, providers and beneficiaries. Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly and individuals with disabilities; financing long-term services and supports (including nursing home care) not covered by Medicare or private insurance; supporting providers; achieving national health care objectives like improving health and managing epidemics, and playing a major role in supporting state economies. Medicaid will play an even larger role under health reform by expanding coverage to reduce the number of uninsured. However, these current and future roles that Medicaid plays, particularly for low-income, vulnerable and currently uninsured Americans are at risk under a federal block grant. Analysis of the impact of prior block grant proposals for Medicaid as well as experience with the Children's Health Insurance Program (CHIP), the Temporary Assistance for Needy Families (TANF) and other programs provide evidence of problems with pre-set and limited financing such as funding levels that do not adjust to program needs and difficulties allocating funds across states.

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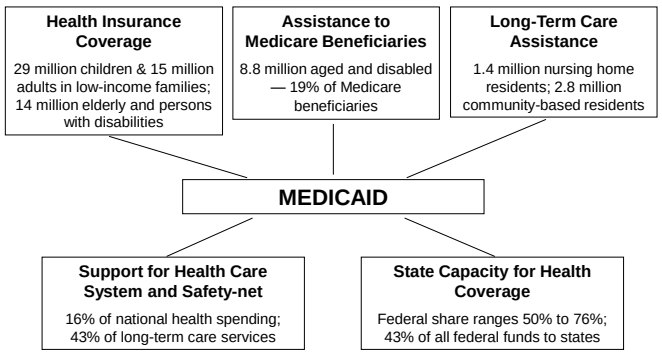
OVERVIEW OF CURRENT MEDICAID PROGRAM

Medicaid provides an entitlement to coverage for individuals eligible for the program and fulfills other vital roles in the health care system. Medicaid covers low-income individuals who meet categorical and income standards including children and parents, individuals with diverse physical and mental conditions and disabilities, and seniors. Any individual who meets the requirements for eligibility set by a state is entitled to receive the services that state offers. States are not able to impose waiting lists or enrollment caps on the program. The federal government sets minimum eligibility standards, and states may expand beyond these minimum levels. Individuals on Medicaid tend to be poorer and sicker than individuals with private insurance. Spending for high-need populations accounts for the majority of Medicaid spending. The elderly and disabled only account for one in four enrollees, but about two-thirds of Medicaid costs. Medicaid provides assistance to low-income Medicare beneficiaries, finances long-term services and supports, supports health care providers (especially safety-net providers) and helps states finance health coverage (Figure 1).

Figure 1

Medicaid Today

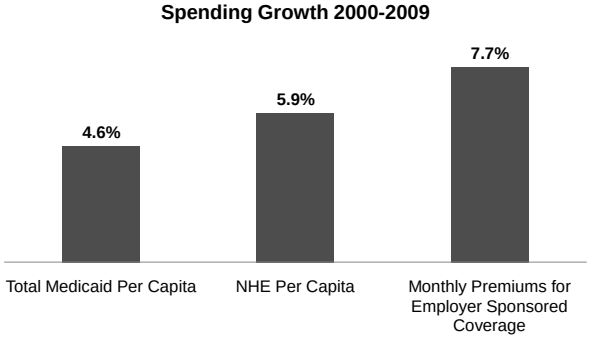


Medicaid also guarantees states to federal matching payments with no cap to support the entitlement to coverage and state program choices. The federal matching percentage (FMAP) is based on a formula in statute that provides relatively poorer states more federal assistance. On average, the federal government pays about 57% of Medicaid costs, but the rate ranges from a floor of 50% to a high of 75% in 2011. The amount of federal financing is not limited by a cap, but federal legislation and regulations can limit or expand uses of federal Medicaid dollars. This financing model allows federal funds to flow to states based on actual costs and needs. If medical costs rise, more individuals enroll due to an economic downturn; if a state raises payment rates or if there is an epidemic (such as HIV/AIDS) or a natural disaster Medicaid can respond and federal payments automatically adjust to reflect the added costs of the program. In exchange for receiving federal matching funds, states must meet minimum federal program rules. Beyond these federal minimums, states have a broad set of options to determine who is eligible, what benefits are covered, how care is delivered, and how and what providers are paid.[2] In addition, a state can obtain a waiver to operate its Medicaid program in ways not otherwise allowed under federal rules. As a result of this flexibility there is large variation across Medicaid programs.

Medicaid spending per enrollee has grown slower than private health care spending over the last decade. The primary driver behind Medicaid spending growth is increases in Medicaid caseload, especially during economic downturns. On a per capita basis, however, total Medicaid spending growth over the last decade was (4.6%) slower than the rate of growth in private insurance premiums (7.7%) (Figure 2). Compared to private health insurers, Medicaid generally has lower payment rates to providers and lower administrative costs, but these spending trends show that Medicaid is a relatively efficient program.

Figure 2

Medicaid spending growth per enrollee has been slower than growth in private health spending.



SOURCE: Urban Institute, 2010. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

FEDERAL BUDGET PRESSURE AND EFFORTS TO RESTRUCTURE MEDICAID FINANCING

Estimates show large federal deficits over the next decade. The Congressional Budget Office (CBO) estimates the FY 2011 budget deficit will be $1.48 trillion. Over the next decade, 2012 to 2021, the CBO estimates that the deficit will total $6.97 trillion. Medicaid accounted for 8% of federal outlays in FY 2010 (while Medicare accounted for 15% and Social Security for 20%). Over the next decade, federal Medicaid spending is projected to grow at an average annual rate of 7% per year; this in part reflects the addition of 16 million Medicaid enrollees under health reform.[3] Driven primarily by the impact of the recession, states have experienced record declines in revenue, large budget shortfalls and increases in demand for public programs, including Medicaid.

Several proposals have been put forward to reduce the federal deficit over the long-term that include changes to Medicaid. Some proposals would convert part or all of Medicaid from an open-ended federal-state matching program to a federal block grant to the states. While a block grant can be structured in a number of ways, block grants generally provide fixed federal allotments to states that are based on current expenditures trended forward using a pre-determined growth rate. Some Medicaid proposals would cap all federal Medicaid spending, while others would convert portions of the program to a block grant (i.e. acute or long-term care).[4] Some governors are calling for additional flexibility in Medicaid to cut eligibility, charge premiums, increase co-payments, and restructure benefits in response to the state fiscal challenges beyond the scope of what is allowed under current state options. Some governors are also seeking Medicaid demonstration waivers to make changes that are not otherwise allowable under current law and a few governors have asked for full authority for Medicaid under a block grant from the federal government. Some issues that arise in proposals to shift from an entitlement program to a block grant include the following.[5]

- ***To achieve federal savings, Medicaid funding would be set below expected levels.*** The federal government's financial exposure would be limited to these pre-set amounts. States would have more programmatic flexibility with respect to eligibility, benefits, and provider payments, but the financial exposure to states, localities, providers, and beneficiaries would not be limited.
- ***Pre-determined levels of funding would not be responsive to program needs.*** The current financing structure helps states to manage costs that are hard to predict like economic downturns, health care inflation, and increased demand of long-term care, as well as costs related to epidemics (such as HIV/AIDS) and emergencies (such as hurricanes or terrorist attacks). A block grant does not adjust for these needs.
- ***Allocating limited federal funds equitably across states is difficult.*** In a capped financing arrangement, federal funds paid to states are based on a pre-set formula. Any formula that benefits some states may disadvantage others and it is very difficult to adjust caps based on changing needs of states. Generally, allotments are based on current spending which may lock into place past policy decisions.
- ***A block grant would eliminate the entitlement to Medicaid, so coverage would not be guaranteed.*** Under the current Medicaid program, eligible individuals are entitled to have payment made on their behalf for a defined set of benefits, and states are entitled to federal matching payments for the costs of this coverage. Under a block grant, there would be no individual entitlement. Instead, states would have flexibility to stay within their fixed allotment of federal matching funds by cutting back on current eligibility levels or by freezing new enrollment (meaning some seniors or low-income children meeting eligibility criteria could be barred from enrollment in Medicaid).
- ***To maintain accountability for federal dollars, capped financing arrangements generally impose requirements on states.*** While it seems clear that it would be difficult for a state to maintain an individual entitlement to coverage without a state entitlement to federal funds to share in the cost of that coverage, it is unclear what rules and requirements would be maintained under a Medicaid block grant. Some block grant structures would require a set amount of state spending and / or some federal requirements related to eligibility, benefits or payment levels to maintain accountability for how large sums of federal funds are expended.

IMPLICATIONS OF CHANGES TO CURRENT MEDICAID PROGRAM

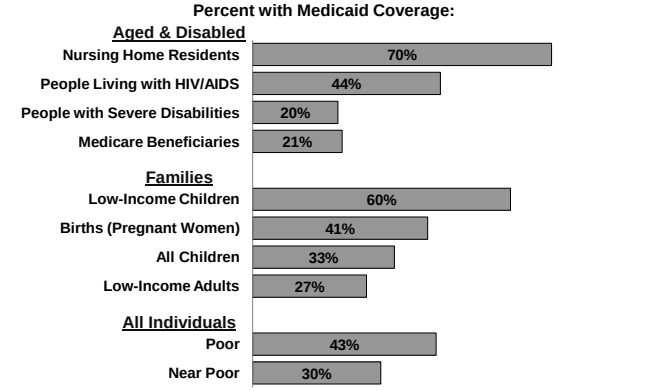
Converting all or part of Medicaid into a block grant could help reduce the federal deficit, but has implications for beneficiaries (including duals, individuals eligible for Medicare and Medicaid), the delivery of long-term care services, providers and states. In exchange for limited and capped federal financing, a block grant would remove federal requirements and the entitlement for individuals which would fundamentally alter the scope and role of Medicaid.

Beneficiaries. Today, Medicaid provides health coverage to about 60 million individuals, one in three children (60% of all low-income children), four in ten births, and 70 percent of nursing home residents (Figure 3). While the elderly and individuals with disabilities account for one in four beneficiaries, they account for two-thirds of the costs (Figure 4). For those covered by the program, Medicaid provides a comprehensive set of benefits with limited out-of-pocket burdens to reflect the incomes and health needs of those enrolled. Without Medicaid, most of these individuals would otherwise be uninsured. Most individuals covered by Medicaid do not have access to private coverage that is affordable or adequate to meet often complex needs.

Under a block grant, the entitlement to coverage would be eliminated and states could cut back on current eligibility levels. States would also have the flexibility to freeze enrollment and impose waiting lists. These restrictions would result in more uninsured. Under a block grant, states could also have additional flexibility around benefits and cost sharing, so current program safeguards would not be guaranteed. This could shift costs to beneficiaries and limit access to care. Looking ahead, a Medicaid block grant is not consistent with the expansion of Medicaid eligibility under health reform that would help reduce the number of uninsured Americans.

Figure 3

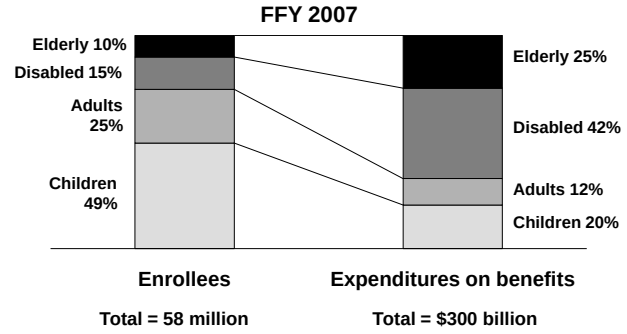
Medicaid has a critical role for selected populations.



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS; Birth data from *Maternal and Child Health Update: States Make Progress Towards Improving Systems of Care*, National Governors Association, 2010; Medicare data from USDHHS.

Figure 4

The elderly and disabled account for the majority of Medicaid spending.



SOURCE: KCMU and Urban Institute estimates based on 2007 MSIS and CMS64 data.

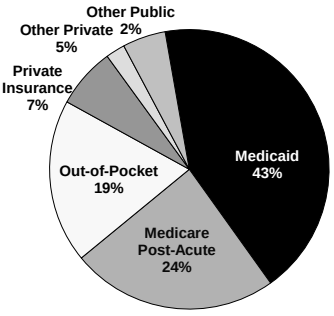
Long-term Care and Assistance for Duals. Prior to the current requirements to maintain coverage levels, states have flexibility to set income and level of care requirements for eligibility for long-term care. States also have flexibility to determine how long-term care services are delivered (in an institution or in the community). Medicaid now pays for the care of 1.4 million nursing home residents and provides home- and community-based services to 2.8 million low-income elderly and disabled at risk of placement in a nursing home. States have the option to provide home- and community-based (HCBS) with capped enrollment and many states have instituted long waiting lists for HCBS services.[6] Medicaid finances about 43% of all long-term care costs (Figure 5). Under current law, Medicaid pays premiums and cost-sharing for low-income Medicare beneficiaries, and covers long-term care services that Medicare does not cover. Duals represent 15% of enrollees and 40% of Medicaid spending (Figure 6).

Under a Medicaid block grant with limited financing, states could limit eligibility, extend waiting lists to nursing home services and impose longer wait lists for HCBS. It could also allow states to eliminate current protections

against the impoverishment of spouses of nursing home residents and to require adult children and other family members to contribute to the costs of nursing home care of their Medicaid-eligible parents or siblings. States could have the flexibility to eliminate or reduce their payments for premiums and cost-sharing on behalf of duals, shifting these costs onto low-income Medicare beneficiaries. States could also increase cost-sharing, reduce the scope or stop providing services (such as long-term care) to duals even though Medicare and private insurance do not generally cover these needs.

Figure 5

Medicaid is the primary payer for long-term care services.



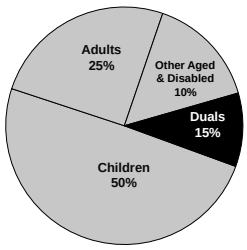
Total in 2009 = $240 billion

NOTE: Total LTC expenditures includes spending on nursing home, home health services, and home and community-based waiver services. All home and community-based waiver services are attributed to Medicaid. Total excludes residential care facilities for mental retardation, mental health, or substance abuse.
SOURCE: KCMU estimates based on CMS National Health Accounts data, 2008.

Figure 6

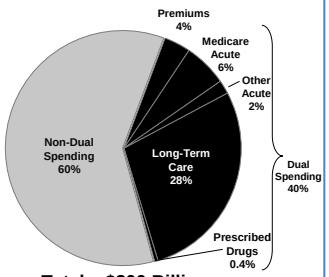
Duals account for 40% of Medicaid spending.

Medicaid Enrollment



Total = 58 Million

Medicaid Spending



Total = $300 Billion

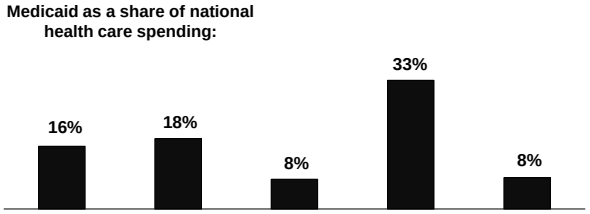
SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Providers. Medicaid accounts for one of every six dollars of health care spending and nearly one in three dollars spent on nursing home care (Figure 7). Medicaid is also the country's major payer for mental health services, HIV/AIDS care, care for children with special needs and births. Like private health insurance, Medicaid purchases services from hospitals, physicians and other providers in the private healthcare market place. About 72% of Medicaid enrollees receive care through some type of managed care plan (Figure 8). Many public hospitals, children's hospitals, rural providers and community health centers rely heavily on Medicaid revenue. Most providers already receive Medicaid payments that are lower than the cost of providing care to program beneficiaries and due to the recent recession, many states have imposed additional restrictions on provider rates. Most providers can shift these costs to other payers, but providers that rely more heavily on Medicaid cannot shift costs as easily as other providers. Many of these same providers also rely on Disproportionate Share Hospital (DSH) payments. These payments help hospitals that serve a disproportionate share of low-income or uninsured patients.

Figure 7

Medicaid provides support for providers and services in the health care system.

Medicaid as a share of national health care spending:

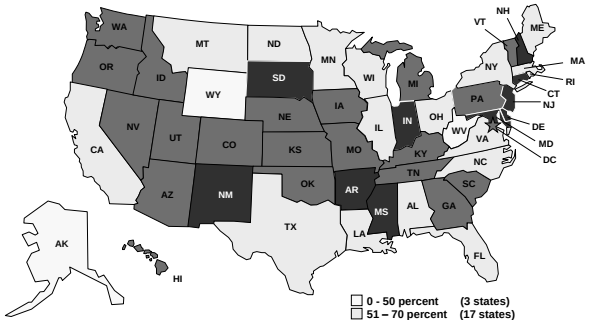


	Total Health Services and Supplies	Hospital Care	Professional Services	Nursing Home Care	Prescription Drugs
Total National Spending (billions)	$2,330	$759	$675	$137	$250

NOTE: Does not include spending on CHIP. Definition of nursing home care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. SOURCE: CMS, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, January 2011. Data for 2009.

Figure 8

Most Medicaid enrollees receive care through private managed care.



U.S. Average June 2009 = 71.7%

NOTE: Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits.
SOURCE: Medicaid Managed Care Enrollment as of June 30, 2009. Centers for Medicare and Medicaid Services, special data request, July 2010.

Limiting federal Medicaid funding would place additional pressures on providers, resulting in fewer providers able to serve Medicaid and uninsured patients. Increasing the differential between Medicaid and private insurance payments would result in less access for beneficiaries and could hamper efforts to improve quality of care. Medicaid is the largest payer for long-term care (both institutional and community-based) and public mental health services. Because Medicaid represents such a large share of revenues for these provider types, they would be at a higher risk if federal Medicaid financing were reduced or capped. Many safety-net providers that rely heavily on Medicaid revenues make trauma and emergency room services available to the broader community. Limited provider payments could restrict these services.

States. Medicaid is a major source of coverage for low-income individuals but also serves as an engine in state economies supporting millions of private sector jobs (Figure 9). While Medicaid is a large budget item for states, it also represents the largest source of federal revenue to states. Medicaid spending represents 16% of state general fund spending (a far second to spending for elementary and secondary education) and accounts for 43% of all federal revenue to states (Figure 10).

By reducing the amount of federal funds flowing to states, a Medicaid block grant could have a dampening effect on state revenues, state economic growth, and employment. The current matching structure allows states to share the risks related to increased enrollment during an economic downturn, medical inflation costs, as well as the growing costs related to providing long-term services and supports for the elderly and individuals with disabilities. Reducing federal funds to states would not reduce these needs or costs, but could shift additional costs to the states. The current matching structure also supports state choices and flexibility. All states have expanded eligibility levels (especially for children) and benefits (like prescription drugs) beyond those required by federal law and are able to receive federal matching payments to do so. States that have limited programs with few optional services would have a harder time making program reductions or expanding their programs in the future if federal support were capped based on current funding levels.

Figure 9

Medicaid helps to generate jobs in state economies.

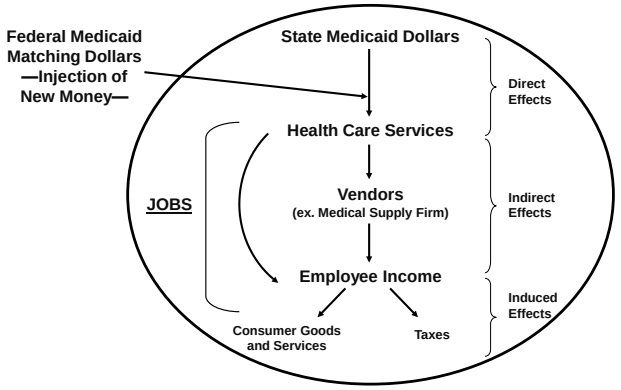
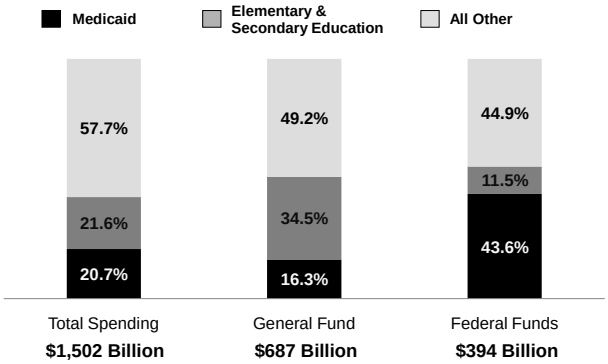


Figure 10

Medicaid is the largest source of federal revenue for states



SOURCE: National Association of State Budget Officers, 2008 State Expenditure Report, Dec. 2009 (Data for FY 2008)

Federal Government. Under a block grant, the federal government would achieve savings and deficit reduction by capping federal liability and financing for Medicaid. In exchange, the federal government would give states more program flexibility. It is unclear what standards or requirements would be in place to maintain accountability for federal spending under a block grant. However, additional flexibility could mean even greater variation across state programs, and less federal accountability in exchange for limited federal finacing.

LESSONS FROM FEDERAL BLOCK GRANTS

Experience shows that in exchange for limited liability and predictable levels of federal financing, capped federal financing can result in a mismatch between funding and needs and problems distributing funds across states.

Prior Medicaid block grant proposals show that pre-set funding levels would not match needs and would have resulted in a re-distribution of funding across states. Previous proposals to convert Medicaid into a block grant were advanced in 1981, 1995 and 2003. Analysis of the 1981 and 1995 proposals shows that the federal funds provided did not match actual federal Medicaid spending. Under the 1981 proposal, funding would have been 6% less than actual spending over five years and 26% less over a ten-year period. Under the 1995 proposal, capped funding would have exceeded actual spending by 3% over the first five years, but would have been lower by 2% over a seven-year period. Annually, funding would have been significantly lower than actual spending in 2001 and 2002 during an economic downturn.[7] Other analyses showed that the 1995 proposals would have resulted in significant distributional effects across states as well as large reductions in federal payments.[8] Other proposals would cap a portion of the Medicaid program (like acute or long-term care).[9]

Children's Health Insurance Program (CHIP) has been able to succeed due to the underpinning of Medicaid and the availability of increased federal funds; however, it has been difficult to set capped allotments to meet program needs and to allocate funds across states. CHIP is regarded as a success in expanding coverage for low-income, uninsured children not eligible for Medicaid; however, CHIP covers a much smaller number of children and has a much more narrow purpose than Medicaid. CHIP relies heavily on Medicaid to provide a more complex set of benefits to higher need children and to absorb increased enrollment during economic downturns as incomes fall. Under CHIP, additional federal dollars and a higher matching rate relative to Medicaid provided incentives to states to provide coverage to low-income children. Despite its success, the CHIP experience highlights challenges with capped federal funding. Under CHIP, federal funding was set 10 years in advance as part of the Balanced Budget Act of 1997. The allotments were set too high initially and then too low as programs matured and demands increased, but states were able to rely on carry-over funds from prior year allotments. There was also difficulty in distributing funding to states. The pre-set formula was not responsive to states' needs leaving some states with surpluses and other states needed additional funds to keep up with program costs and enrollment growth. Some states with insufficient federal allotments froze enrollment and imposed waiting lists.[10]

Programs with capped federal financing like Temporary Assistance for Needy Families (TANF) illustrate that federal funding often does not keep pace with needs or provide guarantees for benefits. Legislation in 1996 created the TANF block grant to replace an entitlement to cash welfare for poor families with children. The basic TANF block grant has been set at $16.6 billion since 1996, so the purchasing power has fallen over time.[11] During the last recession, TANF caseloads increased by just 13% while food stamp caseloads grew by 45%. In 1994-1995, for every 100 families in poverty, AFDC served 75 families; in 2009 TANF served 28 out of every 100 families in poverty showing that the program has not kept pace with needs.[12] The number of families in poverty increased by 41% from 1995 to 2009.[13] Other capped programs also show that funding levels do not keep pace with need. Under the AIDS Drug Assistance Program (ADAP), states must cap enrollment, impose waiting lists, reduce the number of drugs offered, tighten eligibility, or make other cuts.[14] Federal funding for the Indian Health Service (IHS) has not kept pace with growth in the American Indians and Alaska Natives (AIAN) population and health care costs, providing about 59% of needed funds for the system. Under other block grants, like the Social Services Block Grant, the real value of the grant has declined significantly over time.[15]

The Rhode Island Global Waiver set federal Medicaid payments above anticipated levels; applied to all states this would increase federal spending. Rhode Island's Global Waiver has been pointed to as a Medicaid block grant that can provide additional flexibility and yield savings for both the federal government and state. However, the state received more federal financing than was projected in the absence of the waiver. If all states were able to get the Rhode Island deal, this could significantly increase federal costs, not generate savings. Analysis also shows that the state could have achieved most of the policy objectives (such as moving individuals from nursing homes to community-based care) under current law without the waiver and the spending cap.[16]

OUTLOOK

As policy makers struggle to balance state budgets and reduce the federal deficit, there is discussion about fundamental changes to the financing structure of Medicaid. From the federal perspective, capped financing at lower than anticipated levels may limit liability, make funding predictable and generate savings. In exchange for benefits to the federal budget, these changes could mean shifting costs and risk to states, localities, providers and beneficiaries. According to the CBO analysis of the budget resolution proposed by the House Budget Committee on April 5, 2011, "Although states would have additional flexibility to design and manage their Medicaid programs and might achieve greater efficiencies in the delivery of care than they do under current law, the large projected reduction in federal payments would probably require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law."[17]

Medicaid currently plays a significant role in providing care to many low-income individuals including children, the elderly and individuals with disabilities, financing long-term services and supports not covered by Medicare or private insurance, supporting providers, achieving national health care objectives like improving health and managing epidemics, and promoting economic growth in state economies. Medicaid will play an even larger role under health reform by expanding coverage to reduce the number of uninsured. However, these current and future roles that Medicaid plays, particularly for low-income, vulnerable and currently uninsured Americans, are at risk under a federal block grant.

ENDNOTES

[1] *The Path to Prosperity: Restoring America's Promise*. FY 2012 Budget Resolution, House Budget Committee, April 5, 2011.

[2] Recognizing the increased demands on Medicaid during the recent recession, under the American Recovery and Reinvestment Act (ARRA), Congress provided states a temporary increase in the federal share of matching payments. As a condition of receiving these enhanced federal funds, states were required to maintain eligibility rules and enrollment procedures that are no more restrictive than those in effect on July 1, 2008. The ACA included a similar "maintenance of effort" (MOE) requirement to keep Medicaid and CHIP coverage stable until coverage expands under reform—to receive federal Medicaid funds, states must maintain eligibility and enrollment policies that are no more restrictive than those in place at the time the ACA was enacted (March 23, 2010) until 2014 for adults and until 2019 for children in Medicaid and CHIP. An exception allows states facing a budget deficit to reduce eligibility for non-disabled adults above 133% FPL.

[3] Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid. Congressional Budget Office, March 18, 2011. http://www.cbo.gov/budget/factsheets/2011b/medicaid.pdf

[4] *Comparison of Medicaid Provisions in Deficit-Reduction Proposals*. Kaiser Commission on Medicaid and the Uninsured, December 2010. http://www.kff.org/medicaid/upload/8129.pdf.

[5] *Medicaid and Block Grant Financing Compared.* Kaiser Commission on Medicaid and the Uninsured, January 2004.

[6] *Medicaid Home and Community-Based Service Programs: Data Update.* Kaiser Commission on Medicaid and the Uninsured, February 2011.

[7] Jeanne Lambrew, "Making Medicaid a Block Grant Program, Analysis of the Implications of Past Proposals." *The Milbank Quarterly,* Vol. 83 No.1, January 2005

[8] John Holahan and David Liska, *The Impact of the "Medigrant" Plan on Federal Payments to State*s. Kaiser Commission on Medicaid and the Uninsured, December 2005.

[9] *Reducing the Deficit: Spending and Revenue Options.* Congressional Budget Office, March 2011. http://www.cbo.gov/doc.cfm?index=12085&zzz=41594

[10] Cindy Mann and Robin Rudowitz, *Financing Health Coverage: The State Children's Health Insurance Experience.* Kaiser Commission on Medicaid and the Uninsured, February 2005.

[11] As part of ARRA, Congress created a $5 billion Emergency Fund for 2009 and 2010 designed to provide aid to states with increased caseloads during the economic downturn.

[12] *TANF Responded Unevenly to Increase in Need During Downturn: State-By-State Fact Sheets.* January 25, 2011

[13] Weighted average poverty thresholds for nonfarm families, by size, 1959–2009 (in dollars), data for families of 4, http://www.ssa.gov/policy/docs/statcomps/supplement/2010/3e.html#table3.e1

[14] *National ADAP Monitoring Project Annual Report: Summary and Detailed Findings*, National Alliance of State and Territorial AIDS Directors and the Kaiser Family Foundation, April 2009.

[15] *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy*. Kaiser Commission on Medicaid and the Uninsured, November 2006.

[16] Jesse Cross-Call and Judith Solomon, *Rhode Island Global Waiver not a Model for How States Would Fare Under a Medicaid Block Grant*, Center for Budget and Policy Priorities, March 2011.

[17] Letter to Honorable Paul Ryan, *Long-Term Analysis of a Budget Proposal by Chairman Ryan,* Congressional Budget Office, April 5.

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This publication (#8173) is available on the Kaiser Family Foundation's website at www.kff.org.

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