



March 17, 2017

Honorable Diane Black
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Re: Establishing a Medicaid Block Grant

Dear Madam Chairman:

Among the possibilities for making structural changes to the Medicaid program that would lead to federal savings are proposals that would cap the amounts states receive from the federal government to operate the program. For example, either overall caps—implemented with block grants at amounts that would not change with fluctuations in enrollment—or per-enrollee caps could generate budgetary savings in greater or lesser amounts depending on how they are designed.

Besides the decision about whether to set overall or per-enrollee caps, other key design choices would significantly affect the level of federal spending, including these:

- What categories of program spending and eligibility to include in the spending limits,
- Which year's spending to use as the base and what growth factor (or percentage rate) to use to increase the caps over time,
- How much flexibility to grant to states to make changes to the program, and
- How to treat the optional expansion of coverage under the Affordable Care Act.

The effects of various choices could interact in complicated ways.¹

¹ For additional information about those design choices, see Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), Health Option 2, pp. 221–230, www.cbo.gov/budget-options/2016/52229.

Under the American Health Care Act (AHCA), beginning in 2020, the federal government would establish a limit on the amount of reimbursement it provides to states under the Medicaid program using a per-enrollee cap. The limit for each state would be set by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits in the state in 2016. The Secretary of Health and Human Services would then inflate the average per-enrollee cost for each state by the growth in the medical care component of the consumer price index (CPI-M). Such a limit on federal reimbursement would reduce outlays because Medicaid spending under current law (after certain adjustments) is projected to grow on a per-enrollee basis at a faster rate than the CPI-M.²

I understand from committee staff that there is interest in designing an option for a state to receive funding through a block grant with financial parameters comparable to the per-enrollee cap. The grant would be coupled with new flexibility, by which the federal government could cede more control to states for a range of program features. In CBO's judgment, depending on the specifics of the proposal, such an option could be more attractive to some states than the AHCA's per-enrollee cap, and its inclusion in the legislation would have budgetary effects relative to those under both current law and the AHCA.

I hope this information is helpful to you. If you have additional questions, please contact me.

Sincerely,



Keith Hall
Director

cc: Honorable Todd Rokita
Honorable Bruce Westerman
Honorable Gary J. Palmer

² Those adjustments account for changes that would occur under the AHCA to the population of enrollees to whom eligibility was expanded under the ACA. See Congressional Budget Office, cost estimate for The American Health Care Act, Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017 (March 13, 2017), www.cbo.gov/publication/52486.