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Issue Brief

Block-granting Medicaid

Promise and Peril for New York's Healthcare System

by Bill Hammond

As they continue working toward a replacement for President Barack Obama's Affordable Care Act, Republicans in Congress are debating various forms of "block grant" financing for Medicaid, the nation's safety-net health plan for the poor and disabled.

Reform in the shape of a block grant would replace the current system of open-ended matching aid, which has been blamed for encouraging overspending and gamesmanship as some states sought to maximize their federal funding. A prime example of the phenomenon is New York, which operates one of the costliest Medicaid programs in the country.

Based on how previous federal block grants have worked, analysts have widely assumed that such a change would mean billions less in federal spending on Medicaid over time – especially in high-cost states such as New York.

But not all block grants are created equal.

Some versions proposed in Congress would indeed tightly constrain future funding for Medicaid. Other variations would make little or no practical difference. Some might allow federal funding to grow faster than the pattern of recent years, even in high-cost New York.

Seemingly technical details – such as the choice of an inflation factor – could add or subtract billions of dollars from New York's long-term bottom line.

Further complicating the picture is the uncertain fate of the ACA's Medicaid expansion, which included enhanced federal aid for states that participated. New York, which

Published by the Empire Center for Public Policy, Inc.

had broad eligibility rules before the ACA, currently receives about $2 billion a year in such funding, which is on track to exceed $4 billion in 2019. Some GOP plans would allow some or all that funding to continue; others would phase it out or eliminate it completely.

Regardless of how that question is decided, a block grant could affect New York's Medicaid funding, for better or worse, for decades to come. And the possible outcomes vary dramatically.

Had a traditional lump-sum block grant been put in place in 2002, the state would have received at least $8 billion a year less than its actual aid allotment for 2012. Under another variation – a per-capita cap trended by the medical inflation rate – the state could have received $5 billion more in federal aid than it did in 2012.

As it happens, the latter, more generous option is what the House Republicans included in their American Health Care Act, as introduced on March 6. If the legislation were enacted in its current form, New York would face a short-term loss of Medicaid expansion funds, but relatively little effect – and possibly no effect – on the long-term growth rate of its program.

With so much at stake, this report summarizes some of the leading block grant proposals, analyzes their potential impacts on the state's finances, and offers a guide for what New Yorkers should watch as the debate in Washington unfolds.

Table 1: New York's three-way split
Sources of Medicaid funds in FY 2017

	Dollars (in billions)	Percent
Federal share	32.4	51.3
State share	22.3	35.3
Local share (NYC and 57 counties)	8.4	13.3
Total	63.2	

Source: Division of the Budget

Background on Medicaid

Launched in 1966 as part of President Lyndon Johnson's "Great Society" program, Medicaid is a safety-net health plan for the poor.

It covers 74 million people, or more than one in five Americans. In New York, it covers more than 6 million residents, or one in three.[1]

Its beneficiaries include elderly residents of nursing homes, people who are too disabled to support themselves, low-income children and their parents, and, in some states, including New York, low-income adults.

States manage the program within guidelines established by the federal government, and both benefits and eligibility standards vary considerably across the country.

The costs of the program are divided between the federal and state governments according to a matching percentage based on a state's per-capita income, ranging from 50 percent to 76 percent. As a relatively wealthy state, New York's matching share is 50 percent.

Within that formula, the amount of federal aid a state can receive is theoretically unlimited. No matter how much New York chooses to spend on valid Medicaid expenses, Washington is obliged to match that amount, dollar for dollar – a system that has long been faulted for encouraging overspending and gamesmanship by state governments.

The Affordable Care Act of 2010 sought to expand Medicaid nationwide as part of a strategy to move the country toward universal insurance coverage. States were expected to raise their widely varying eligibility thresholds to 138 percent of the federal poverty level. The federal government committed to pay the full cost of newly eligible beneficiaries, tapering down to 90 percent after 2019.[2]

The ACA also boosted federal matching aid for the Children's Health Insurance Program (CHIP), which covers children in families making up to 200 percent of the poverty level.

New York was one of a handful of states whose Medicaid programs already covered most of the so-called expansion population. For these states, the ACA included extra matching aid for able-bodied adult beneficiaries, which started at 75 percent in 2014 and rose to 90 percent for 2020 and thereafter.[3]

The expansion was originally mandatory for states, but the Supreme Court ruled that provision of the ACA unconstitutional, making the expansion optional. New York chose to participate, along with 30 other states and the District of Columbia. Nineteen opted out.[4]

Medicaid's matching-aid system creates perverse incentives. In effect, it rewards states for increasing spending and penalizes them for cutting costs.

After the expansion took effect, nationwide Medicaid and CHIP enrollment rose by 16 million, or 28 percent, accounting for more than half of the insurance gains under Obamacare. New York's enrollment, which was already high by national standards, grew by 712,000, or 13 percent.[5]

Nationwide, Medicaid spending rose 21 percent in the first two years, from $456 billion in 2013 to $552 billion in 2015, with the federal government absorbing the bulk of the increase.[6]

Over that same two-year period, spending on Medicaid in New York rose 10 percent, from $53 billion to $58 billion. Its federal aid increased from $26 billion to $32 billion, or from 50 percent to 55 percent. The state's share of the cost, including $8 billion a year contributed by New York City and the 57 counties, held roughly flat at $26 billion.[7]

Perverse incentives

Policymakers have long recognized that Medicaid's matching-aid system creates perverse incentives. In effect, it rewards states for increasing spending and penalizes them for cutting costs.

For every $1 million that New York puts into its program, it draws down another $1 million in federal aid, resulting in a combined gain of $2 million for its healthcare system and the broader economy. Conversely, the state must cut $2 million out of its healthcare system to save just $1 million for its own budget.

Some states have responded to these incentives by redefining existing health-related programs as Medicaid benefits, so they could shift part of the cost to Washington. Some have imposed special taxes on health-care providers and plowed the revenue into Medicaid, knowing that the same money, plus the federal match, would ultimately flow back to those same providers. New York has been among the most aggressive states in pursuing both strategies.

Under the Medicaid expansion, with its higher matching rates, the perverse incentives for states to expand their programs became even stronger. Those who participated reaped billions more in aid, which they are now at risk of losing if Congress rolls the expansion back.

Another objection to the current system is that it reinforces economic disparities. Wealthier states that can afford to spend heavily on Medicaid are rewarded with more aid from Washington, while poorer states tend to receive correspondingly less.

New York as outlier

Few states have gone after federal Medicaid funding more aggressively than New York.

Since the program's beginning, state lawmakers have generally offered as many benefits to as many categories of people as federal officials

would allow – repeatedly applying for special waivers that authorized New York to go beyond the normal statutory guidelines.

For much of that history, the state divided its share of the cost with county governments, so that every $1 spent by the state was matched by another $2 – $1.50 from Washington and 50 cents from the counties.

The state also levied various taxes on healthcare, most notably through the Health Care Reform Act. First passed in 1996, the law now brings in $5.7 billion a year, mostly from two surcharges on health insurance, making it the state's third-largest source of revenue, after income and sales taxes.[8]

Two-thirds of HCRA revenues, or $3.8 billion, flow into the Medicaid budget, drawing another $3.8 billion in matching federal funds.[9]

Largely because of its expansive policies, New York ranked as the country's costliest Medicaid program as recently as 2010 – topping even California, with almost twice the population.[10]

In more recent years, however, New York has become less of an outlier. The state has taken steps to improve efficiency, primarily by enrolling most recipients in commercial health plans. Per-recipient spending declined by 11 percent from 2011 to 2016.[11] The state has also frozen the counties' contributions to the program.

Governor Andrew Cuomo and the Legislature capped the growth of the state's Medicaid contribution at a rolling average of the medical inflation rate – a rule the state has largely adhered to, even as enrollment surged.

Still, New York receives federal aid significantly out of proportion to its size. With just 6 percent of the population, it accounted for 9 percent of federal Medicaid spending in 2015, or $33 billion.[12]

That included more than $2 billion in extra matching aid under the Medicaid expansion.[13] If the expansion stays in place through 2019, that amount will likely rise to more than $4 billion.

What 'block grant' means

As a strategy for controlling Medicaid costs, leaders in Congress are proposing to adopt some variation of "block grant" financing.

The proposals vary widely – and some are not truly block grants in the traditional sense. But all would impose a limit on how much states can draw in federal funding, a first in the history of the program.

Any such change would likely have significant ramifications for New York. Whether those effects would be good or bad for the state's healthcare system, or its finances, depends heavily on details that remain in flux.

Under the purest form of the concept, the federal government's open-ended promise of matching aid would be replaced by a predetermined lump sum allocated to each state, which would either be held flat or adjusted by an inflation factor each year.

Proposed reforms would impose a limit on how much states can draw in federal funding, a first in the history of the program.

In theory, this flips the financial incentives: The additional costs of any program expansion would be fully borne by states, at least to the extent that they exceeded the inflation factor. At the same time, states would keep the full amount of savings if, say, they reduced enrollment, trimmed benefits, or otherwise controlled expenses.

When this model was applied to federal welfare funding in 1996, New York reaped a substantial windfall as welfare rolls plunged.

Other variations being considered by Congress – sometimes loosely referred to as "block grants" – would work very differently:

Per-capita allotment: States would receive a fixed amount per recipient in each of several categories (i.e., aged, blind and disabled, children, adults). This would keep pace with changes in enrollment and reflect the much higher cost of caring for a nursing home resident versus a healthy child. Usually, these allotments would be trended forward by an inflation rate.

Per-capita cap: This would set a maximum on how much aid states would receive per recipient in each category. The limit would be trended forward by an inflation rate. Below the cap, states would continue to draw funds based on their matching rate.

Having limited the federal government's contribution, Washington would also scale back its control of the program. States would be given more flexibility to raise or lower eligibility limits, and to add or subtract benefits, without needing federal permission for every step.

Some versions of a block grant would also encourage states to experiment with broader structural changes, such as work requirements and premium copayments for beneficiaries.

In and of itself, this type of reform does not necessarily mean lower funding right away. The welfare block grants of the 1990s were set at the high-water mark of state spending at the time. Some proposals for Medicaid would allow spending to continue at or above its current levels.

However, proponents of the change have portrayed it as a way of controlling costs and reducing the federal budget deficit. Some in Congress are pushing for a block grant that would significantly slow or cut overall Medicaid funding for states – which would likely lead many states to curtail enrollment and benefits.

While block-grant financing addresses some flaws in the current system, it comes with potential downsides of its own. Unless it adjusts for changes in enrollment, it would accentuate the fiscal pressures on states during economic downturns, when more people would lose jobs and sign up for Medicaid. Unless it somehow ties state funding levels to a national norm, a block grant system would also tend to lock in existing inequities between high- and low-spending states.

Competing proposals

As this report goes to press, Republicans who have a majority in both houses of Congress have yet to find consensus on repealing and replacing the Affordable Care Act.

The basic concept of a block grant for Medicaid features in several of the GOP plans and has been endorsed by President Donald Trump. But the details are sometimes sketchy and vary considerably from one plan to another. All include various degrees of management flexibility for states.

A Better Way: One of the more fleshed-out proposals is found in the healthcare section of "A Better Way," a series of white papers produced by House Republicans in 2016.[14]

This version gives states two choices for collecting federal Medicaid funds starting in 2019: a per-capita cap or a true lump-sum block grant.

The per-capita cap would be based on the average amount the state spent in 2016 on recipients in four main categories – aged, blind and disabled, children, and adults – multiplied by the number of recipients in each. The amount would be "adjusted for inflation" at an unspecified rate. Below the capped amount, the state would continue to receive aid based on its pre-ACA matching rate.

For the lump-sum option, the "A Better Way" does not specify a base year or mention an inflation adjustment.

As for the extra aid states have been receiving under the ACA's Medicaid expansion, the plan says it "would be slowly phased down each year until it reached the state's normal [matching aid] level," but does not give a schedule.

The Hatch plan: The Patient CARE Act, sponsored by Senator Orrin Hatch (R-UT), calls for a per-capita allotment that would apply to adults and children on Medicaid, but not the elderly or disabled (whose funding would continue under the matching system). The allotment would be based on the previous year's spending in the two covered categories, trended forward by the Consumer Price Index plus one percentage point.[15]

States would receive federal aid only for recipients at or below the federal poverty level, which would exclude part of the ACA's expansion population.

The American Health Care Act: Backed by the House GOP leadership and introduced on March 6, AHCA differs from the "Better Way" plan in key respects.[16]

Supporters of block-granting Medicaid have framed it as a way of slowing spending growth and reducing the federal deficit, fueling fear that it will lead to dramatic cutbacks in coverage and benefits for Medicaid recipients.

The bill would distribute federal Medicaid funding under a per-capita cap starting in 2020. It does not include the option of a lump-sum block grant.

It makes allotments based on average spending in five Medicaid categories – aged, blind and disabled, children, adults, and expansion enrollees – combining data from two base years, 2016 and 2019. The allotments would be trended forward by the medical inflation rate and multiplied by enrollment in the four categories to produce an overall cap on federal aid. Under the cap, states would continue to collect funding based on their pre-ACA matching percentage.

The bill would freeze enhanced aid for the Medicaid expansion after December 31, 2019. But people already signed up at that point could keep their coverage indefinitely – until they get a job with benefits, for example, or their income rises above 138 percent of poverty.

Enhanced federal aid for those individuals would continue as long as they stayed in the program.

A retrospective illustration

Supporters of block-granting Medicaid have framed it as a way of slowing spending growth

and reducing the federal deficit, fueling fear that it will lead to dramatic cutbacks in coverage and benefits for Medicaid recipients.

Recent reports – based on previous legislation introduced in Congress – have projected that repealing the Medicaid expansion and switching to a block grant would cause millions to lose coverage and cost states hundreds of billions of dollars in the years ahead.

Some proposals now on the table, however, differ significantly from those earlier bills, resulting in far smaller reductions to federal aid.

To better understand how various versions of a block grant would work, we analyzed what would have happened to New York's Medicaid budget if the reforms had been implemented 15 years ago.

As a baseline, we used the state's actual 2002 spending on four major categories of recipients: the elderly, the blind and disabled, children, and adults.[17] We trended spending numbers forward by 10 years according to different block-grant scenarios, multiplied those figures by the 2012 enrollment numbers, then compared the results to how much aid New York actually received in 2012.[18] (See Table 2 below.)

Under a lump-sum block grant with no inflation rate, New York's federal aid would have stayed flat at $15 billion – regardless of growing enrollment and rising medical costs. After a decade, the block grant would have still been $15 billion, which is $8 billion less than what the state received under the matching formula in 2012.

If the lump sum had been adjusted for the basic Consumer Price Index, or for the medical CPI, federal funding would still have fallen short of actual funding during the same period, but by narrower margins.

Switching to a per-capita allotment also narrows the gap, because federal aid would have risen in line with enrollment.

If adjusted for inflation, however, a per-capita allotment would have generated more federal

Table 2: All 'block grants' are not created equal

How different Medicaid reform models would have affected New York (in billions)

	2002	2012	Change from 2012 actual
Actual payments	$15.3	$23.5	None
Lump sum block grant, no inflation adjustment	$15.3	$15.3	$(8.2)
Lump sum block grant adjusted for CPI	$15.3	$19.6	$(4.0)
Per capita allotment, no inflation adjustment	$15.3	$22.3	$(1.3)
Per capita allotment, adjusted for CPI	$15.3	$19.8	$(3.7)
Per capita allotment, adjusted for medical CPI	$15.3	$28.8	$5.2

Source: Empire Center Calculations

aid than New York received under the matching formula. If adjusted for Consumer Price Index for medical care, the hypothetical surplus would have grown to more than $5 billion.

A block grant of that type, therefore, would have represented a windfall for New York. The state could have provided the same Medicaid benefits to the same number of recipients at the same cost while spending just $18 billion of the state's money, instead of $23 billion.

This most generous formula, as it happens, is the one that House leaders included in the American Health Care Act – with a crucial distinction: the dollar amount generated is not an allotment, but a cap. Below the cap, the state would continue collecting aid on a 50 percent matching basis. Thus, in the hypothetical example, the state could have drawn up to $29 billion in aid, but only if it spent $29 billion of its own money.

The CBO estimates that the House GOP's American Health Care Act would reduce federal Medicaid spending by a cumulative $880 billion.

In reality, the state spent $23 billion in 2012, which was matched by $23 billion in federal aid. The cap would have had no practical impact.

Forecasting the future

The Congressional Budget Office estimates that the House GOP's American Health Care Act would reduce federal Medicaid spending by a cumulative total of $880 billion over the 10 year period from 2017 to 2026. The impact would grow over time, from a reduction of $3 billion in 2017, to $155 billion, or 25 percent, in 2026.[19]

Since New York currently accounts for about 9 percent of federal Medicaid spending, it could expect to lose on the order of $80 billion over 10 years if AHCA becomes law.

The CBO report suggests that the cuts under AHCA would be far less severe than under previous House GOP proposals.

A House Republican budget plan from 2012 would have cut Medicaid funding by an estimated $1.7 trillion from 2013 to 2022, or more than twice the 10-year impact of AHCA.[20]

That amount included $932 billion from repealing the Medicaid expansion and $810 billion from a block grant that was tied to the Consumer Price Index and population growth. New York's share of the cuts was estimated to be $176 billion over 10 years, including $73 billion from Medicaid expansion repeal and $103 billion from the block grant.[21]

In 2016, the House Budget Committee under Representative Tom Price (now Health and Human Services secretary in the Trump administration) called for $2.1 trillion in cuts to Medicaid over 10 years, including $1 trillion attributed to a Medicaid block grant.[22]

The cuts in AHCA are thus less than half the size of those in previous GOP plans – and appear to result mostly from repeal of the Medicaid expansion. The CBO said the per-capita cap would "reduce outlays," but did not specify how much.

Separately, it estimated that imposing the cap would cause states to spend only marginally less – a total of $7.1 billion over 10 years – suggesting that the impact would be small.

The CBO based its analysis of the per-capita cap on a projection that the Consumer Price Index for medical services will be lower than the per-capita growth rate Medicaid spending over the next decade – averaging 3.7 percent versus 4.4 percent. This would keep federal aid lower than it otherwise would have been.

However, this would mark a departure from the recent pattern, which has been that Medicaid per-capita spending has run lower than medical inflation.

From 2001 to 2011, for example, the growth of New York per-capita Medicaid spending was lower than medical inflation in eight out of 11 years. The same was true for the nationwide spending rate.

Cumulatively for the 11-year period, New York's per-capita spending rose 24 percent, the national average went up 35 percent, and medical inflation was 53 percent.

Some analysts have projected that this pattern will continue – including the Medicaid and CHIP Payment Advisory Commission, a congressional advisory group.[23] If so, New York and other states would be less likely to hit the cap, and their ability to draw federal matching aid would not be affected.

The welfare precedent

Washington has used the block grant concept before, most notably as part of the welfare reform law signed by President Bill Clinton in 1996. Although the impact of that reform on the poor remains much disputed, it turned out to be a net positive for New York's finances.

The 1996 law essentially froze each state's allotment of federal welfare funding at the dollar amount it had been receiving when reform was enacted – in New York's case, $2.5 billion a year. At the same time, the law put restrictions on cash benefits, including time limits and a requirement that able-bodied recipients participate in work-related activities, such as community service. (These requirements paralleled measures that New York City had previously implemented under Mayor Rudolph Giuliani.)

With the new rules in place, the state's welfare rolls dropped by almost two-thirds, or 1 million people, over the next decade[24] – causing a corresponding drop in cost. Yet federal funding stayed at $2.5 billion, creating a surplus that the state could use for other social programs, such as job training, child care, and the Earned Income Tax Credit.

Welfare enrollment has sometimes surged during economic downturns, but it has never come close to returning to its pre-1996 level. To this day, New York's spending on Temporary Assistance to Needy Families, the main cash welfare program, remains less than its original block grant of $2.5 billion.[25]

Whether a Medicaid block grant would play out in the same way is unclear.

Faced with a loss of federal aid and empowered with more management flexibility, states could save money by scaling back eligibility, imposing work requirements, cutting waste, improving efficiency, and finding creative ways to provide affordable coverage.

For one thing, cash benefits can be replaced with even a low-paying job. There is no such readily available alternative for health coverage. Some Medicaid recipients are too sick to work. Others are employed, but in jobs that don't come with health benefits. And few will be able to afford to buy insurance on their own, especially if, as seems likely, Congress repeals the income-based tax credits that are a core component of the ACA. Affordability would be a particular issue for low-income New Yorkers, who face some of the highest insurance premiums in the country, partly as a result of state-imposed taxes and coverage mandates.

Faced with a loss of federal aid and empowered with more management flexibility, states could save money by scaling back eligibility or imposing work requirements that discourage people from enrolling. Or they could focus on cutting waste, improving efficiency, and finding creative ways to provide affordable coverage – steps that might be of benefit to all consumers.

Which directions states pursue would depend heavily on how a block grant is designed.

Factors to watch

Which structure is used?

A true lump-sum block grant – even with a generous baseline – would primarily benefit states in which Medicaid enrollment either declines or remains flat. Indeed, it would create a strong incentive for states to limit eligibility and trim their rolls going forward.

A per-capita allotment, if sufficiently large and appropriately adjusted for inflation, would encourage states to control costs without cutting enrollment.

A per-capita cap could limit growth in federal spending. But if the cap is set higher than spending was otherwise likely to go – as it would be under AHCA – it would essentially represent a continuation of the matching-funds status quo, with the same perverse incentives.

How is the baseline calculated?

A block grant, allotment, or cap that eliminates Medicaid expansion funding would almost certainly cause millions to lose their current coverage. Many if not most would struggle to afford coverage with tax credits alone.

Leaving the Medicaid expansion funds in place, but phasing them down or limiting their growth going forward, would enable states to continue supporting the expansion population in some fashion – perhaps through supplemental tax credits.

What trend factor is used?

The faster that federal Medicaid funding is allowed to grow, the less strain will be put on state budgets – and the less pressure will be created to control costs.

Is funding tied to national averages?

One downside of the matching aid system is that it contributes to inequity: wealthier states that can afford to spend more on Medicaid draw more federal funding, while poorer states draw less. A case could be made that Washington should pay every state the same amount per recipient – which would encourage

high-spending states to cut costs while rewarding low-spending states for being efficient.

Although this type of change is not part of leading proposals currently under consideration, it would represent a particular challenge to New York's finances. As of 2011, the last year for which fully comparable data are available, lowering its aid to the national average would have been the equivalent of a 37 percent cut.

What is the effective date?

The original draft of AHCA puts off the biggest changes until after December 31, 2019, which gives states time to prepare and minimizes the impact on New York's budget for 2017-18.[26]

However, press reports indicate that President Trump is open to moving the effective date up to January 1, 2018, giving states only a matter of months and significantly affecting the upcoming New York State budget – which is due March 31, well before Congress is expected to take final action on any Obamacare replacement.[27]

Conclusion

As a state that spends heavily on Medicaid, New York is especially vulnerable to changes in Washington that cut funding or even slow its growth over time. In some respects, the state has shown in recent years that it can discipline its healthcare spending.

Since 2012, the state's Medicaid program has been operating under a "global cap" imposed by Governor Cuomo and the Legislature. This cap holds growth of the state's share of Medicaid spending to the 10-year average of medical inflation. With some exceptions, the state has generally held to this cap, despite significant increases in enrollment. As a result, per-capita spending has declined in several recent years.

The proposed cap in the House GOP bill, which would rise with medical inflation on a per-enrollee basis, represents far less of a constraint in the long term than the state's self-imposed policy. Compared to far more restrictive block grant proposals of the past, this plan looks like a dodged bullet for New York.

Because it's a cap rather than a per-capita allotment, however, it could be viewed as a missed opportunity. A per-capita allotment, if sufficiently large and adequately trended forward, would mesh well with the state's own goal of controlling Medicaid costs.

Under a federal waiver painstakingly negotiated in 2014, New York stands to receive an extra $8 billion in Medicaid funding from Washington over a five-year period. That money represents a portion of how much the state's cost-cutting efforts will have saved for the federal government. Under a per-capita allotment, the state would have automatically kept 100 percent of any savings – and without jumping through hoops.

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