



POLICY BRIEF

A Review of the Medicaid Program

Its Impact in Washington State and Efforts at Reform in Other States

by Roger Stark, MD
Health Care Policy Analyst

May 2009



A Review of the Medicaid Program *Its Impact in Washington State and Efforts at Reform in Other States*

by Roger Stark, MD
Health Care Policy Analyst

May 2009

Contents

Introduction	2
Medicaid History	3
The Original Medicaid Program	5
The Expansions of Medicaid Since Enactment	5
The Medicaid Program Today	7
How Medicaid's Funding Structure Drives Costs	8
Medicaid Crowds out Private Coverage	9
Medicaid's Administrative Complexity	9
Medicaid's Low Reimbursement Rates Reduce Access to Doctors	9
Medicaid Distorts the Health Care Market	10
Medicaid Coverage Does Not Mean Access to Better Care	11
The Washington State Medicaid Program	11
Medicaid Reform Plans in Washington and Other States	13
Washington State	14
Oregon	14
Tennessee	15
Massachusetts	15
South Carolina	16
Rhode Island	17
Indiana	17
Florida	17
Louisiana	18
Other States	18
New Federal Plans for Medicaid	19
Can Medicaid be Reformed?	20
The Success of Welfare Entitlement Reform	21
Recommendations for Reforming Medicaid	22
Conclusion	22
Addendum	23
About the Author	24

A Review of the Medicaid Program

Its Impact in Washington State and Efforts at Reform in Other States

Key Findings

- Medicaid is an open-ended entitlement with no defined limit on the number of beneficiaries or cost
- Medicaid is a state/federal partnership which encourages states to spend more on the program to receive the federal match
- Unless rates of spending slow down, Medicaid spending will double by 2017. At an average growth rate of eight percent a year, Medicaid is the fastest growing federal entitlement program
- The total spent on Medicaid in Washington in fiscal year 2008 was \$4.13 billion, with a projected 4.7% increase to \$4.32 billion in 2009
- Medicaid has expanded from covering children and their families who earn up to 133% of the Federal Poverty Level to, in some states, families who earn up to 300% of the FPL
- Medicaid has never been subjected to meaningful national reform, although several states have new plans with potentially successful reforms
- Medicaid has encouraged overutilization of health care resources without real evidence of improving health of the poor

Recommendations

- Health savings accounts for recipients
- Pursue fraud aggressively
- Tighten eligibility requirements (at least back to the original 133% of the FPL)
- Block grants to the states
- Freeze funding at 2005 or even 2007 levels

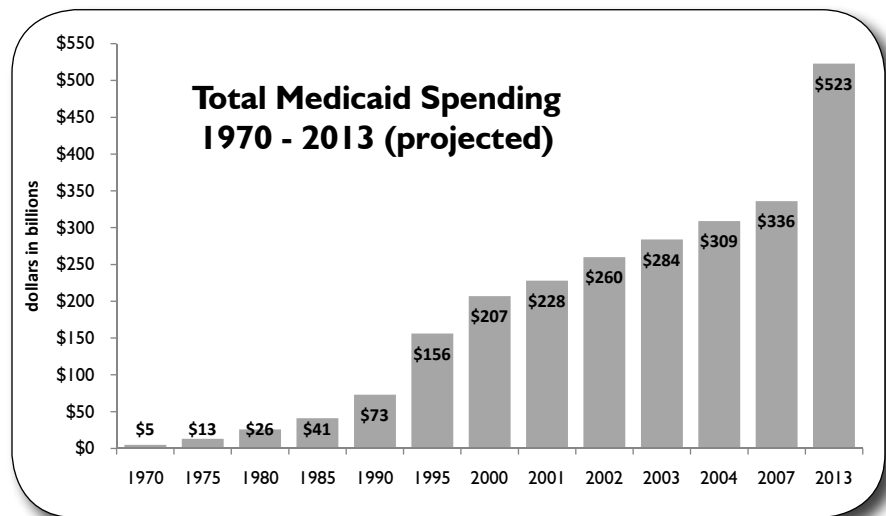
by Roger Stark, MD
Health Care Policy Analyst

May 2009

Introduction

The Medicaid program began in 1965 with the passage of title XIX of the Social Security Act. It has always been an entitlement, with no defined limit on the number of beneficiaries or the cost of the program. As long as a person meets the legal criteria for participation in the program, that person receives Medicaid benefits, regardless of total cost. From the beginning, a link was established between Medicaid eligibility and the welfare program, Aid to Families with Dependant Children (AFDC).¹ Medicaid is now the largest health insurance system in the United States and is the largest means-tested health care program in the world.

The cost of Medicaid is shared between federal and state governments. Each state receives federal money on a sliding scale based on average personal income, with poorer states getting a higher percentage of federal funds. At present, the average match for Medicaid spending is 57% in federal money and 43% in state funds.² Medicaid spending is now the fastest growing line item in virtually every state in the country. In 2006, Medicaid spending accounted for 23% of the average state budget.³



Total spending on Medicaid in Washington State was \$4.13 billion for fiscal 2008. Not counting the federal stimulus package, this number is projected to increase 4.7% to \$4.32 billion for fiscal 2009. The contribution from Washington State taxpayers for both years is 48% of the total which is higher than the average of 43%.

According to the National Association of State Budget Officers, Medicaid

¹ "Medicaid Legislative History, 1965-2000," The Kaiser Commission on Medicaid and the Uninsured, Appendix 1, p 175, 2000.

² "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.

³ "2005 State Expenditure Report," National Association of State Budget Officers, November 2006, pages 2-3.

costs will grow much faster than state revenue growth for the foreseeable future, meaning the program will take up an ever-growing share of state budgets. For 2007, Medicaid expenses for federal and state governments combined were \$336 billion. This number is projected to reach \$523 billion by 2013, a 56% increase in just six years.⁴

Unless rates of spending slow down, Medicaid spending will double by 2017.⁵ At an average growth rate of eight percent a year, Medicaid is the fastest growing federal entitlement program.⁶ Without changes made to current policies, the non-partisan Congressional Budget Office estimates that the Medicaid program alone will account for almost six percent of the nation's Gross Domestic Product by 2017.⁷

This paper briefly discusses the history leading up to the passage of the Medicaid program, outlines the original features of the program, and broadly describes the changes made to the program over the last 43 years. The paper then reviews the Washington State Medicaid program, the various plans in other states, and changes being made at the federal level. The study concludes with a discussion of potential reform measures that would control Medicaid costs and help make the program financially sustainable into the future.

Medicaid History

In 1883, Germany became the first country to socialize its health care and provide state funded, and state controlled, medical care for all of its citizens.⁸ By 1915, at least ten major European and Asian countries had compulsory, state controlled, taxpayer funded health programs.⁹ In the United States, the Socialist Party began pushing for nationalized medicine as early as 1904.

The U.S. entry into World War I in 1917 stalled the socialized medicine movement in this country, because of its negative association with Germany and Russia. Enthusiasm for government controlled health care decreased dramatically over the following ten years. By 1932, after adjusting for today's dollar, total health care spending was 4% of Gross Domestic Product (GDP).¹⁰ For comparison, that amount today is 17% of GDP.

A mandatory government-run retirement program, Social Security, was enacted in the U.S. as part of President Roosevelt's New Deal in 1935. Nationalized health care was originally part of the Social Security Act, but it was removed because of the national opposition to government-managed socialized medicine. Roosevelt and socialized retirement advocates were concerned that the entire Social Security Act would die in Congress if government controlled health care were part of the bill.¹¹ By 1946, only 11% of Americans said they favored

⁴ "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.

⁵ "Federal Medicaid Payments," CBO March 2008 Baseline: Medicaid, Congressional Budget Office, March 2008, at www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf.

⁶ "The Budget and Economic Outlook, 2007 – 2017, An Update," Congressional Budget Office, August 2007, page 9, at www.cbo.gov/ftpdocs/85xx/doc8565/08-23-Update07.pdf.

⁷ *Ibid*, page 3.

⁸ "Health of Nations: An International Perspective on U.S. Health Care Reform," by Laurene A. Graig, Congressional Quarterly Press, Washington, D.C., 1999, page 45.

⁹ "Compulsory Health Insurance: The Continuing American Debate," by Ronald L. Numbers, et al., Greenwood Press, Westport, Connecticut, 1982, page ix.

¹⁰ "Health Spending in 1998: Signals of Change," by Katherine Levit, et al., *Health Affairs* 19, no. 1:124, 1998, at www.medscape.com/viewarticle/409814.

¹¹ "Medicare: Policy and Politics," by Eugene Feingold, Chandler Publishing Company, San Francisco, 1966, pages 91-92.

socialized medicine.¹²

Instead of nationalizing U.S. health care at one stroke, advocates settled on an incremental approach to establishing government control. President Truman favored this step-by-step concept and, except for the brief effort to pass “HillaryCare” in 1993, the incremental approach has been the method favored by socialized medicine advocates for achieving nationalized health care in this country.¹³

After World War II, rapid population growth showed there were not enough hospitals to take care of the growing number of citizens. Congress passed the Hill-Burton Act in 1946, which provided federal money to communities to assist them in building hospitals. In exchange, these hospitals were required to provide a certain percentage of their services to poor and indigent patients. The Hill-Burton Act expired in 1978, but it clearly established the federal government’s ongoing role as a funder and controller of health care services in the United States.¹⁴

In 1960, President Eisenhower signed the Medical Assistance for the Aged Act, or as it is more commonly called, the Kerr-Mills bill.¹⁵ This was a voluntary, means-tested program that made 77% of all seniors eligible for government assistance in paying health care expenses. Like Medicaid today, the Kerr-Mills program was a combined federal and state-funded program. By 1964, 40 states, including Washington State, and the District of Columbia had Kerr-Mills plans in place. Also like Medicaid, the states were allowed to determine their own eligibility requirements and benefits packages under the program.

For many activists who sought complete nationalized health care, the Kerr-Mills bill did not go nearly far enough. In their view the main shortcomings were that the program was voluntary and limited to low-income citizens. Also, states were slow to establish functioning programs. Consequently, a broader program, called the King-Anderson bill, was proposed in the early 1960s. The King-Anderson bill became the legislative basis for Medicare.

The American Medical Association (AMA) strongly favored expanding the Kerr-Mills law into a broader program called “Elder Care.”¹⁶

The powerful chairman of the Ways and Means Committee, Representative Wilbur Mills (D-Ark.) proposed what he called a “three-layer-cake.” The King-Anderson bill would become Medicare Part A, a Republican proposal called “Better Care” would become Medicare Part B, and the American Medical Association’s “Elder Care,” targeted to the poor, would become Medicaid.¹⁷

Chairman Mills concluded that in this way all major political interests represented in Washington would be served, and all of them would then lobby for the passage of the Medicare and Medicaid bill. Medicaid was created as a separate program by design. The idea was to assure Medicare supporters that

¹² “Public Opinion 1935-1946,” by Hadley Cantril, Princeton University Press, 1951, pages, 442-443.

¹³ “The Origins of Health Insurance for the Aged,” by Howard S. Berliner, *International Journal of Health Services* 3, no. 3, 1973, page 465.

¹⁴ “Health Care in the U.S. Today: Problems and Solutions,” by Roger Stark, MD, BookSurge/Amazon Publishing, 2007, page 15.

¹⁵ “Summary of Major Provisions of the Medical Assistance for the Aged Program (Kerr-Mills Law): Public Law 86-778,” U.S. House of Representatives, Committee on Ways and Means, 89-1, 1965, pgs 1-4.

¹⁶ “Medicare: A Handbook on the History and Issues of Health Care Services for the Elderly,” by William Pearman and Philip Starr, Garland Publishing, New York, 1988, page 8.

¹⁷ “Wilbur Mills Oral History Interviews,” transcript, by Michael L. Gillette, LBJ Library, Interview II, tape 1, side 1, pages II-3, March 25, 1987.

their program for the elderly would not be swamped by costly, high-needs poor and disabled patients.

Chairman Mills' strategy worked, and both programs were signed into law by President Johnson in 1965.

The Original Medicaid Program

As enacted, Medicaid became Title XIX of the Social Security Act. As an entitlement, the new law committed the federal government to providing health services, regardless of cost, to all U.S. residents who met the eligibility requirements.¹⁸ Eligibility was initially defined as:

1. All children in families with incomes of less than 133% of the federal poverty level (FPL)
2. All adult caretakers of eligible children
3. Elderly people not receiving supplemental social security benefits
4. The legally blind
5. The disabled

Medicaid was set up as a joint federal and state program, with Washington D.C. providing broad national guidelines and the individual states deciding the type, duration, and amount of health services to be provided, as well as the eligibility criteria. The original thinking in Congress was that a joint program would cost less since state legislators would not be as willing to spend their state dollars on an entitlement plan. The rapid expansion in the eligibility and cost of the program since then, however, has shown this supposition to be false.

States that wanted to participate in Medicaid were required to submit a comprehensive plan to the Medicaid office in Washington, D.C. Although the federal guidelines were intended by Congress merely to set broad parameters, the original regulations ran to 220 pages of single spaced type and included specific mandatory eligibility and benefit criteria.

Originally, not all poor people qualified for Medicaid. Eligibility requirements based on income have been a moving target for state officials down through the years, and have led to a variety of added state-only programs for the poor and uninsured people who are not covered by the federal Medicaid program. Likewise, a number of states have attempted to fold Medicaid into their state-specific plans of universal coverage, while exempting Medicare recipients. This approach will be discussed further in the section New Medicaid Plans in Other States.

The Expansions of Medicaid Since Enactment

Since its inception, Medicaid alone has seen massive expansions in the scope and cost of the program. Although government administrators took at least a year to get the program running, by 1967 Congress was already amending the original bill and adding new benefits.¹⁹ The federal legislative language also shows a shift from “allowing” states to voluntarily increase eligibility and benefits to “requiring” states to expand these same criteria. The result has been a significant increase in the share of state budgets claimed by the federal program.

¹⁸ “Medicaid Milestones, 1965 - 2000,” History, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, at www.cms.hhs.gov/History/Downloads/Medicaid-Milestones.pdf.

¹⁹ “Brief Summaries of Medicare and Medicaid,” by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.

The shift by federal officials to imposing new eligibility and benefit requirements on the states undermined the original rationale for making Medicaid a matching funds program: that state officials would manage the program carefully to avoid spending too much of state taxpayers' money. This single policy decision has contributed greatly to the financial instability and unpredictability of the program.

Several landmark decisions involving Medicaid expansion warrant particular attention. First, the major welfare reform of 1996 for the first time repealed a federal entitlement program, Aid to Families with Dependent Children (AFDC). Congress replaced it with block grants to the states, called Temporary Assistance to Needy Families (TANF).

This should have effectively decoupled Medicaid from welfare assistance and could have given states more control over their own health care programs for poor residents. Instead, Congress amended the welfare reform bill with Section 1931, which required states to continue to cover the medical care of families meeting the 1996 AFDC criteria. The 1996 welfare reform itself has been a tremendous success,²⁰ relieving millions of families of dependence on monthly government payments and opening opportunities for a life of work, self-reliance and independence. Yet Congress barred the Medicaid program from participating in the same reform, and today it remains an extremely costly, wasteful and ever-expanding federal program.

A second landmark piece of legislation was passage of Title XXI of the Social Security Act, enacted as part of the Balanced Budget Act of 1997. The bill created the State Children's Health Insurance Program or S-CHIP. This program provides federal block grants to states that extend tax-funded health care coverage to low-income children not eligible for Medicaid, and encourages states to expand public coverage of the disabled up to 250% of the federal poverty level (FPL).

The bill also allows Medicaid recipients to enroll in Managed Care Organizations (MCO) and allows states to opt out of "reasonable and adequate" Medicaid reimbursement for hospitals and nursing homes. So, without specifically expanding Medicaid, the federal government has allowed states to increase their health care spending using federal matching dollars.

Forty-four states now cover children and their families up through 200% of the FPL, and nineteen states cover up to 300% of the FPL through the S-CHIP plan.²¹ Washington State currently covers at 250% of the FPL, which is \$53,500 for a family of four. The Washington legislature passed legislation in 2009 that would expand state-subsidized health care to 300% of the FPL. The legislation also requires the state to offer non-subsidized health insurance to children of families making more than 300% of the FPL.²²

One major result of this expanded government coverage is to crowd out private insurance coverage, as well as an increased tax burden for state tax payers. At these high levels of income eligibility, middle-income families tend to drop their private health insurance and sign up for the tax-subsidized programs.

²⁰ For data demonstrating the success of the 1996 welfare reform law see "Healthy Competition," by Michael F. Cannon and Michael D. Tanner, 2nd edition, The Cato Institute, Washington, D.C., 2007, page 108, and "Poverty Status of People by Family Relationship, Race, and Hispanic Origin, 1959-2005." Table 2, Historical Poverty Tables, U.S. Census Bureau, at www.census.gov/hhes/www/poverty/histpov/hstpov2.html.

²¹ "Challenges of Providing Health Coverage for Children and Parents in a Recession, a 50 State Update," Data Tables, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2009, at www.kff.org/medicaid/upload/7855_TABLES.pdf.

²² Bill Summary at <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2128year=2009>.

The shift by federal officials to imposing new eligibility and benefit requirements on the states undermined the original rationale for making Medicaid a matching funds program: that state officials would manage the program carefully to avoid spending too much of state taxpayers' money. This single policy decision has contributed greatly to the financial instability and unpredictability of the program.

An interesting redistribution of wealth and infusion of cash for states' Medicaid programs came in 1999 with the federal Emergency Supplemental Appropriations bill. This transferred the federal share of settlement funds from the national tobacco litigation to the states. As previously mentioned, Medicaid and state government health care expenses have been the largest and fastest-rising line items for virtually every state budget. The tobacco money provided a welcomed, but limited, one-time cash source for state governors and legislators who found they had financially over-extended their Medicaid programs.

One last example of Medicaid expansion is the Breast and Cervical Cancer Treatment and Prevention Act of 2000. This bill allowed states to cover all uninsured women who were found to need treatment for breast or cervical cancer – regardless of their income level. Clearly this bill goes far beyond the original intent of Medicaid as a program to provide tax-funded health care services only for people who could not otherwise afford it. Under this expansion, even wealthy people can gain access to subsidized health services through the Medicaid program. The result is a further expansion of government subsidy and management into the broader health care system.

The Medicaid Program Today

In the years since it was enacted, Medicaid has grown at twice the rate of health care price inflation, and significantly faster than inflation in the general economy.²³ After over 40 years, the question is whether the program has been a success and at what cost.

The Medicaid program has never lived up to the promises of its advocates in the area of cost containment in health care. The 1965 cost projection for the program in its first year was just under \$500 million dollars. The actual cost in the first year was double that figure, \$1 billion. By 1970, the cost of the program had expanded by 500% to \$5 billion, a period in which inflation increased by only 23%.²⁴

By 2007, total cost (state plus federal spending) was a staggering \$336 billion.²⁵ Interestingly, these numbers are probably low, since only two-thirds of potential Medicaid recipients are signed up at any one point in time.²⁶

Medicaid now represents almost 15% of the \$2.1 trillion in total annual healthcare spending in the United States. In 2007, this single program accounted for fully 7% of all federal spending.²⁷ Over the next ten years its cost is projected to grow at a rate of almost 8% per year, faster than the growth rate of both health care spending and the economy in general.²⁸

Table 1 on the following page shows the national figures for all Medicaid recipients by category and their per-person costs for FY 2005.²⁹

²³ "Medicaid Politics and Policy, 1965-2007," by David G. Smith and Judith D. Moore, Transaction Publishers, New Brunswick, 2008, pages 375-376.

²⁴ Ibid.

²⁵ "2007 State Expenditure Report," National Association of State Budget Officers (NASBO), Fall 2008, at www.nasbo.org/Publications/PDFs/FY07%20State%20Expenditure%20Report.pdf.

²⁶ "Trim3's 2001 Baseline Simulation of Medicaid and SCHIP Eligibility and Enrollment: Methods and Results," by Linda Giannarelli, et al., Urban Institute, TRIM3 Microsimulation Project Technical Paper, April 2005, page 16, at www.aspe.hhs.gov/health/reports/05/medicaid-schip-simulation/index.htm.

²⁷ "State Health Reform, Connecting Medicaid Dollars into Premium Assistance," Table A2, Office of the Actuary, CMS, U.S. Department of Health and Human Services, September 16, 2008.

²⁸ Ibid.

²⁹ "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.

Table I

Category	% of Total Recipients	Cost per Recipient/Year
Children	51%	\$1,667
Adults	24%	\$2,475
Aged	9%	\$13,675
Disabled	16%	\$13,846

Children represent the largest number of Medicaid beneficiaries, yet 87% of the dollars each year are spent on just 25% of recipients, the disabled and aged, reflecting this population's greater health care needs.

As of fiscal 2007, Medicaid provided supplemental coverage for 8.1 million Medicare recipients. This represents a 16% increase from the 7 million recipients in 2004.³⁰ Program officials estimate that for fiscal 2009, a full one-third of Medicaid spending (\$114 billion) will be for the disabled. With the U.S. population aging, they expect this amount to reach \$1.7 trillion in ten years.³¹

One of the original purposes of the Medicaid program was to serve as a fire-wall to protect the Medicare program for the elderly from being overwhelmed by poor and indigent patients. As Medicaid has expanded dramatically in eligibility and spending on the low-income aged, that goal would seem to have been achieved.

How Medicaid's Funding Structure Drives Costs

The original purpose of requiring states to match the federal funds they receive for Medicaid was to control costs. The thinking of congressional sponsors was that state lawmakers would be cautious about obligating the money of their own taxpayers to fund a federal program. In practice, the exact opposite has occurred.

When a state spends one dollar for education, it basically gets one dollar of education services. On the other hand, when a state spends one dollar on Medicaid health care, it effectively gets at least two dollars of health care because of the federal matching funds. Far from being cautious, state lawmakers feel they are leveraging federal dollars by expanding their own Medicaid program. Their reasoning is that limiting their own state's spending only leaves federal money on the table, which will simply go to other states.

Ironically, federal lawmakers feel the same way. Each federal dollar spent on Medicaid leverages a state dollar for the program, so Members of Congress feel they get the full political credit of expanding government coverage of health care, while spending only half the money.

In reality of course, state and federal legislators only have one source of money - the American people - so the same taxpayers are actually paying for both state funds and the federal match.

All federal Medicaid matching funds go into a single budget in each state, and most state legislators are barred by law from running a deficit. Consequently, it is common for state legislators to use federal Medicaid money to balance their

³⁰ "Dual Eligibles: Medicaid's Role in Filling Medicare's Gap," by J. Kasper, et. al. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2004.

³¹ Ibid. See Note 29.

As Medicaid has expanded, it is now estimated that up to one half of current new enrollees already had private coverage.

budgets. In 1981, Congress amended Medicaid to give more federal money, called Disproportionate Share Hospital (DSH) funds, to hospitals that care for a disproportionate share of Medicaid patients. It is now estimated that as much as one-third of DSH funds are spent on other projects by state governments.³²

Medicaid Crowds out Private Coverage

The ultimate consequence of this broad expansion of government into health care has been to “crowd out” private insurance. Over 20% of adults and 27% of children in Medicaid already had private insurance at the time they enrolled.³³ Obviously, many people dropped their private coverage when seemingly “free health care” became available. As Medicaid has expanded, it is now estimated that up to one half of current new enrollees already had private coverage.³⁴

The “crowd out” effect of the Medicaid entitlement has also spilt over into the areas of health care philanthropy, as well as church and fraternal organization involvement in medical care for the poor and needy.³⁵ As the government steps in with a mandatory program, these private entities reduce their charitable services in the area of health care.

Medicaid’s Administrative Complexity

After more than four decades, one might expect that the relationships between state and federal Medicaid administrators would function easily, and that any confusion or complexity in running the program would have been worked out long ago. Quite the contrary relationship exists, however. On a scale of one to five (with five being the most severe), officials in 41 states report a federal administrative burden of four or five.³⁶ According to state program managers, Medicaid is anything but a smooth and efficient program.

Medicaid’s Low Reimbursement Rates Reduce Access to Doctors

Like state program managers, doctors and other health care providers report a dismal level of satisfaction with Medicaid. Even though Congress over the past 20 years has steadily reduced the Medicare program’s doctor reimbursements in real terms, Medicaid reimbursements are still winning the race to the bottom. Despite consistent declines in Medicare payments, Medicaid payments still average only 60% of what Medicare pays to doctors. For doctors, the financial incentive to treat elderly patients under socialized medicine is already low, the reward for helping poor and indigent patients is even lower.

The decreasing reimbursement rate has led doctors to shift costs to patients

³² “Reforming the Medicaid Disproportionate Share Hospital Program,” by Teresa A. Coughlin, et al., *Health Care Financing Review* 22, no. 2, Winter 2000.

³³ “Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?,” by Amy J. Davidoff, et al., *Urban Institute Policy Brief*, series A, no. A-48, October 1, 2001.

³⁴ “Medicaid and SCHIP,” *Cato Handbook for Policymakers*, Chapter 13, The Cato Institute, 7th edition, page 137, at www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

³⁵ “Public Program Crowd-Out of Private Coverage: What Are the Issues?,” by Gestur Davidson, et al., *Robert Wood Johnson Foundation, Research Synthesis Report no.5*, June 2004, at www.rwjf.org/files/research/no5researchreport.pdf.

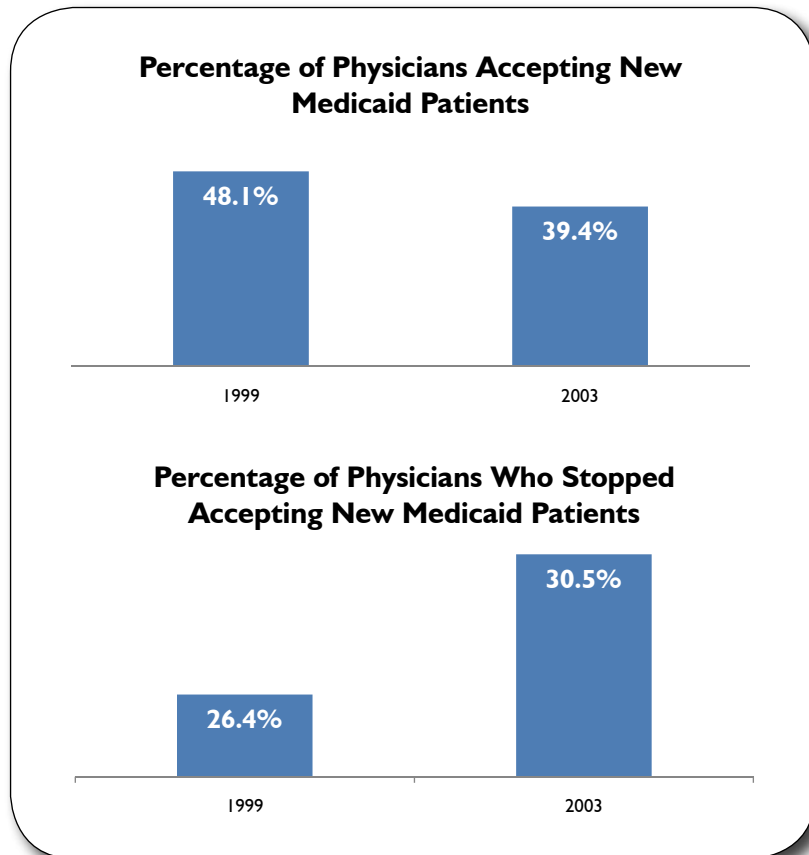
³⁶ “Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn,” by Vernon Smith, Ph.D., et al., *Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, no. 7815, September, 2008, at www.kff.org/medicaid/upload/7815.pdf.

who pay cash or who have private insurance, to over-treat health conditions (in order to earn fees for more services) or to stop taking Medicaid patients altogether.³⁷ In all, Medicaid's low reimbursement rates contribute greatly to the inefficient allocation of health care services in the practice of American medicine.

Medicaid Distorts the Health Care Market

From 1999 to 2003, the percentage of physicians accepting all new Medicaid patients dropped from 48.1% to 39.4%, and those who stopped accepting new Medicaid patients completely increased from 26.4% to 30.5%.³⁸ The unfortunate, but predictable, consequence of low doctor reimbursement is a decrease in access to health care for Medicaid recipients.

The result is a government health care program that actually increases the number of uninsured, when people are forced to drop their private coverage as it becomes unaffordable. If the 10% to 15% in costs added by the Medicaid program were removed, millions of people who are currently uninsured would be able to afford coverage.



When a government entitlement like Medicaid competes with the free market, there are a number of economic consequences as well. Because of cost shifting under Medicaid, consumers with private insurance are burdened with an additional cost of 10% to 15%.³⁹ The result is a government health care program that actually increases the number of uninsured, when people are forced to drop their private coverage as it becomes unaffordable. If the 10% to 15% in costs added by the Medicaid program were removed, millions of people who are currently uninsured would be able to afford coverage.

Another tragic consequence of Medicaid is that it has discouraged both job advancement and entrance into the job market for thousands of people. With

³⁷ "Changes in Medicaid Physician Fees, 1998-2003, Implications for Physician Participation," by Stephen Zuckerman, et al., Health Affairs Web Exclusive, June 23, 2004, page w4-374, at www.content.healthaffairs.org/cgi/content/short/hlthaff.w4.374.

³⁸ "2002 Survey of Physicians About the Medicaid Program," by Julie A. Schoenman and Jacob J. Feldman, Project HOPE Center for Health Affairs, no. 03-1, March 2003.

³⁹ "The Distortionary Effects of Government Procurements: Evidence from Medicaid Prescription Drug Purchasing," by Mark Dugan and Fiona Scott Morton, NBER Working Paper no. 10930, November 2004.

each increase in income, by getting a new job, low-income workers face the risk of losing their Medicaid health benefits. As the scope of Medicaid has increased, the number of people effected by this disincentive has likewise increased.

After 40 years, the Medicaid program is now having a significant negative impact on the private long-term care insurance market as well. Currently, 60% to 75% of private long-term insurance benefits are redundant of Medicaid benefits, creating a strong incentive for people to drop their private coverage.⁴⁰ Current estimates reveal that Medicaid has discouraged 65% to 90% of seniors from purchasing long-term insurance.⁴¹

Medicaid Coverage Does Not Mean Access to Better Care

One of the greatest misconceptions in today's health care debate is that having health insurance is the same as having access to improved health care. There is no data that supports this concept. In fact, after more than 40 years, there is no evidence that Medicaid has improved health outcome for adults or children,⁴² nor is there evidence that increasing Medicaid spending has resulted in better health care for the poor.⁴³ In spite of Medicaid and a host of other social welfare programs, the poverty rate today is about where it was in the late 1960s.⁴⁴

Medicaid is now a fundamental part of the problem of health care access and affordability in the United States, because of the way the program contributes to rising costs. Medicaid is one of the major factors in the third party payer problem in the United States, in which a third party, rather than patients working with doctors, is responsible for covering medical bills.

Today 87% of U.S. health care is funded by third parties, either government or employers. When people do not pay for a product or service, over-utilization of that limited resource will occur and costs will predictably rise, albeit at an unpredictable rate.⁴⁵ If over-utilization in Medicaid is similar to Medicare, the amount could be as high as \$50 billion per year.⁴⁶ Obviously, government exists to provide a vital safety net for its most vulnerable citizens, so the Medicaid program will have to change if it is to survive financially. Practical reforms of Medicaid will be discussed later in this paper.

The Washington State Medicaid Program

Washington State's Medicaid program is administrated by the Department of Social and Health Services (DSHS). In fiscal 2008, DSHS provided tax-funded services to more than 2.1 million people, of which 1,004,673 are enrolled through

⁴⁰ "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," by Jeffrey R. Brown and Amy Finkelstein, NBER Working Paper no. 10989, December 2004, pages 2-3.

⁴¹ Ibid.

⁴² "Does Public Provided Health Insurance Improve the Health of Low-Income Children in the United States?," by Robert Kaestner, et al., NBER Working Paper no. 6887, January 1999, page 1.

⁴³ "Hospital Ownership and Public Medical Spending," by Mark Duggan, NBER Working Paper no. 7789, July 2000.

⁴⁴ "Poverty Status of People by Family Relationship, Race, and Hispanic Origin, 1959-2005." Table 2, Historical Poverty Tables, U.S. Census Bureau, at www.census.gov/hhes/www/poverty/histpov/hstpov2.html.

⁴⁵ "Interdependence and Choices in Distributive Justice, The Welfare Conundrum," by Lee Anne Fennell, Wisconsin Law Review 235, 1994, pages 311-312.

⁴⁶ "Healthy Competition," by Michael F. Cannon and Michael D. Tanner, 2nd edition, The Cato Institute, Washington, D.C., 2007.

17 Medicaid eligible groups.⁴⁷ This is approximately 15% of the 6.5 million people living in the state. The number of Medicaid recipients in Washington is projected to increase by 3% (to 1,036,130) for fiscal 2009.

The total spent on Medicaid in Washington in fiscal 2008 was \$4.13 billion, with a projected 4.7% increase to \$4.32 billion in fiscal 2009. The state's financial contribution for both years is approximately 48% of the total, with the federal government paying 52%. These percentages are virtually identical to the national average. Of course, the money contributed by both state and federal governments comes from the same source: American taxpayers.

Although DSHS lists 17 specific categories for Medicaid recipients, by combining those categories into the four main beneficiary groups, we see that Washington's percentages (see Table 2) are nearly identical to the national numbers. Likewise, costs per recipient are almost the same as the national average, as shown by a comparison of the figures in Tables 1 and 2.⁴⁸

Table 2 - Washington State Figures

Category	% of Total Recipients	Cost per Recipient/Year
Children	52%	\$1,662
Adults	25%	\$1,662
Aged	7%	\$13,846
Disabled	16%	\$13,846

People in Washington's Medicaid program, as in other states, are finding it increasingly difficult to find a doctor, especially in the fee-for-service area. The number of primary care physicians willing to take Medicaid patients has remained fairly stable over the past five years, but the number of specialists has decreased dramatically. It is easy to understand why; Medicaid payments to doctors are 27% lower than Medicare payments, and 47% lower than average private insurance payments.⁴⁹

Currently, Washington ranks 40th out of all states in specialist reimbursement in the Medicaid program. Medicaid's price control mechanism has the effect of reducing the supply of doctors for patients in the program.

Recent recommendations to reduce the damaging effect of price controls include an increase in Medicaid fees paid to doctors, a reduction of administrative burden placed on doctors' offices, and a tax credit option for participating doctors.

Milliman, Inc. prepared a report for the Premara Blue Cross Insurance Company in 2006 and found that 82% of the hospitals in Washington state lost money on Medicaid. On average Medicaid accounted for 13% of revenue, but 16% of hospital expenses. For hospitals in Washington to financially break even on Medicaid patients, the program's revenue would need to increase by 18%.⁵⁰

⁴⁷ The data for this section was provided by the Washington State Department of Social and Health Service, December, 2008.

⁴⁸ DSHS does not record or budget on a per recipient basis. Therefore, the national Medicaid spending averages of 30% for children and adults and 70% for aged and disabled were used for these individual calculations.

⁴⁹ "Preserving Private Physician Participation in Connect, Response and Recommendations to the Recent DSHS Study Regarding Financial Incentives," Washington Community Connect, February 8, 2007, at www.wacommunitiesconnect.org/documents/CCPhysicianIncentivesPositionPaperFINAL2.8.pdf.

⁵⁰ "Payment Level Comparison Between Public Programs and Commercial Health Plans For Washington State Hospitals and Physicians," Will Fox and John Pickering, Milliman, Inc., May, 2006.

Like any other business, hospitals cannot chronically operate with expenses being greater than revenue. Consequently they are forced to shift costs to private payers to make up the deficits that accompany patients in government-controlled programs.

Another sign of limited access to health care is emergency room utilization. Total emergency room visits per one thousand Medicaid recipients in Washington climbed 19% in the four-year period from 1999 to 2003.⁵¹

Although the Washington legislature is debating several major health care proposals, the general attitude in Olympia is to wait until Congress and the Obama Administration act on a possible national health care bill, before attempting sweeping changes at the state level.

Medicaid Reform Plans in Washington and Other States

For years state legislators and governors have been trying to solve the problem of providing tax-funded health insurance while trying to hold down costs. However, since state lawmakers have expanded tax-funded health programs faster than revenues have increased, the vast majority of states are facing significant budget shortfalls in fiscal years 2009 and 2010.

Consequently, several states are designing new programs to limit costs while trying to expand coverage.⁵² A few of these plans are quite ambitious and, by using federal Title XIX waivers, fold Medicaid recipients into these new state programs. Likewise, part of the federal Deficit Reduction Act of 2005 allowed states much more flexibility in designing individual health care programs.

Most states, however, are simply changing eligibility requirements and the type of benefits offered through their Medicaid programs. At least 20 states are cutting back on actual total Medicaid spending for fiscal 2009, and 13 states are reducing health coverage for children and low income families in the S-CHIP program. Further reductions are anticipated in fiscal 2010.⁵³

The concept of states obtaining individual waivers to the broad Medicaid program has existed almost since the entitlement began. Although used sparingly during the 1970s and 1980s, interest in federal waivers has expanded considerably over the past 15 years. After the defeat of "HillaryCare" in 1993, President Clinton streamlined the waiver process to allow states more freedom in increasing government control over their respective health care programs.

Officials in Washington, Oregon and Tennessee were among the first to receive these waivers and to attempt to fold Medicaid into larger health care systems that included the whole state population, except Medicare recipients. All three programs were dismal failures, because of their coercive nature, unsustainable costs and inability to achieve coverage goals.

Specific reform programs that were attempted in various states are described in the following sections.

⁵¹ "Emergency Room Utilization Among Washington State's Medicaid Recipients," Abstr Academy Health Meeting, 2004, 21, abstract no. 1279, www.gateway.nlm.nih.gov.

⁵² "What Works and What Doesn't, A Review of Health Care Reform in the States," by Roger Stark, MD, Washington Policy Center Policy Brief, August 2008, at www.washingtonpolicy.org/Centers/healthcare/policybrief/StateHealthCareReforms.pdf.

⁵³ "Washington Legislative and Regulatory Outlook," by Andrew B. Bressler, Bank of America, July 2008, page 11.

Washington State

In 1992, Washington had 600,000 uninsured residents, which represented about 11% of the population. (Today, Washington has approximately 740,000 uninsured which still represents 11% of the state's 6.5 million residents.) The legislature passed major health care reform, which began in 1993, and was scheduled for full implementation by 1999. The basis of the program was managed competition for all non-Medicare residents in the state. Supporters designed the program to:

1. Decrease program care costs through state-dictated premium caps (price controls)
2. Create universal access by imposing state-wide community rating
3. Expand coverage by imposing new mandates on employers
4. Reduce the number of uninsured by requiring guarantee issue
5. Reduce health costs by promoting public health and prevention

From a practical standpoint, the plan added a powerful new state bureaucracy, raised taxes, added more restrictions on employers and individuals, and in general gave state government more control over health care.

The consequences of the plan were devastating to health coverage in Washington. Fourteen health insurance carriers left the state and the remaining insurance companies were forced to raise premium rates by up to 40%.

Contrary to what program supporters had predicted, the number of uninsured rose 20%, as people were forced to drop private insurance policies they could no longer afford. The state began attracting sick patients from all over the country, because of the new guaranteed issue provision. This provision forced insurance companies to sell a policy to anyone who asked for one, regardless of the policyholder's health condition.

By 1995, it was obvious that the plan was not working and a citizen revolt occurred at the voting booths. Governor Lowry, who had strongly backed the program, chose to sign a repeal bill, rather than face a public vote on a popular initiative to end the program.⁵⁴

Oregon

The Oregon Health Plan was enacted in 1994 and had 132,000 enrollees by 1995. It offered coverage to people under age 65 who did not have individual plans or were not covered by an employer plan, but who were not poor enough to qualify for Medicaid. It did, however, require Medicaid recipients to join a state-approved managed care plan. Consequently the cost of Oregon Medicaid grew from \$750 million in 1994 to \$1.7 billion in the two years after the program was introduced.

Oregon lawmakers found the state could not afford the plan, and likewise private insurance carriers were forced to drop out because the program's price control mechanisms resulted in low reimbursement rates.⁵⁵

By 2004, because of soaring costs, state officials stopped taking new people into the program and total enrollment fell to just 18,000 people. Last year (2008)

⁵⁴ "The rise and repeal of the Washington State Health Plan: Lessons for America's state legislators," by Dr. Robert Cihak, MD, Bob Williams and Peter J. Ferrara, Background, The Heritage Foundation, June 11, 1997, at www.heritage.org/research/healthcare/bg1121.cfm.

⁵⁵ "The Oregon Health Insurance Lottery," by Alan Katz, Health Care Reform Blog, March 4, 2008 at www.alankatz.wordpress.com/2008/03/04the-oregon-health-insurance-lottery.

Oregon held a lottery to add 6,000 new members.⁵⁶

Tennessee

In 1994, Tennessee lawmakers enacted TennCare, a tax-funded program based on eleven state-run managed care organizations (MCOs) that provided unlimited doctor visits, hospital stays and prescription drugs. The state forcibly moved 800,000 Medicaid recipients into the MCOs, and then added 500,000 uninsured or high risk individuals. By 1995, Tennessee closed enrollment in TennCare because of the federal cap of 1.5 million recipients.

Because of rapidly escalating program costs, doctors and hospitals were financially squeezed until 1999, when they successfully lobbied the legislature to receive a certain percent of the state money paid to the MCOs. This new mandate highlighted the fact that MCOs could not provide both cost control and quality care. Three of the eleven MCOs went out of business and the state itself nearly went bankrupt, even though the federal government was paying two-thirds of TennCare's cost. By 2005, 160,000 people who were not Medicaid eligible were removed from the program.⁵⁷

With TennCare finances in shambles, the legislature enacted Cover Tennessee in 2006, in an effort to provide some level of coverage to people who were dropped from the original state plan. Cover Tennessee is designed for enrollees who earn over 250% of the federal poverty level. The program provides mandated first dollar coverage, but no catastrophic coverage above \$25,000 per year, and the patient is restricted from paying more than \$15,000 of this \$25,000 to hospitals.⁵⁸

It is too early to determine the effectiveness of Cover Tennessee, although in the first nine months of 2008, only four out of 15,000 enrollees hit the \$25,000 limit. A concern, however, is that the new program has the same price control mechanism as the failed TennCare plan. This resulted in low provider reimbursement and ultimately low provider participation in the original program.

Massachusetts

In recent years, states have used waivers to design new Medicaid or comprehensive programs with varying levels of coverage. The most ambitious of these new programs was enacted in Massachusetts.⁵⁹

In 2006, the Massachusetts legislature passed comprehensive health care reform in an effort to deal with escalating health costs as well as 550,000 uninsured people (8.6% of the population).⁶⁰ The basics of the plan are a mandate on individuals ages 18 to 64 to buy health insurance (i.e. everyone except Medicare recipients), a mandate on firms with more than 10 employees to provide health coverage or pay a \$295 per employee per year tax into a state fund, and a state run Connector, or insurance exchange, for the individual and small group markets. The state provides subsidies on a sliding scale for residents whose incomes are under 300% of the federal poverty level (FPL). For citizens with

⁵⁶ "Prize in Oregon Lottery is Health Insurance," by Sarah Skidmore, *The Seattle Times*, March 2, 2008.

⁵⁷ "HillaryCare in Tennessee, the disaster that might have been for the entire country," Review and Outlook, *The Wall Street Journal*, December 6, 2004.

⁵⁸ "Cover Tennessee is no magic cure for the uninsured," by Drew Johnson, Tennessee Center of Policy Research, April 28, 2008.

⁵⁹ Ibid. See note 70. Excerpt from pp5-6.

⁶⁰ "Massachusetts sets health plan for nearly all," by Pam Belluck, *The New York Times*, April 15, 2006.

incomes less than the FPL, there is no premium charge.

There are several features of the Connector. All health insurance policies sold though it must provide all state-mandated services, thus artificially increasing costs. It does, however, meet state policymakers' goals of increasing the risk pool and enhancing the portability of insurance.⁶¹

As of early 2008, approximately 350,000 people who were previously uninsured were covered by the state plan.⁶² Unfortunately, the majority of these residents are in the group that is partially or totally subsidized by the state. Individual private plans in the Connector are not selling well. In April 2007, the Connector Board exempted 20% of the uninsured from the individual mandate and increased the subsidy to low income residents. Contrary to what proponents promised, the Connector no longer guarantees universal coverage.

The plan has resulted in a dramatic increase in demand for health services, to the point where primary care doctors in the state are in short supply. In western Massachusetts, some patients wait up to one year to see a family physician. As in Canada and Britain, waiting lists are being used as a tool to ration health care.

The costs of the Connector program have likewise skyrocketed, with early budget over-runs of 30%. Originally, no budget was provided beyond the first three years of the program and Governor Deval has recently asked the federal government for an additional \$869 million in 2009. Even he admits that amount is probably not enough and that program's costs could reach \$1.1 billion. State officials predict a cost over-run in the Connector program of \$4 billion during the next decade.⁶³

In an effort to get spiraling costs under control, lawmakers are considering using price controls to reduce payments to doctors, increasing financial penalties on business (up from the current \$295 per employee per year), raising the state tobacco tax, and adding tighter regulations on private insurers and drug companies. All these policy choices will increase state control while lowering the supply of health care services.

No mention has been made of decreasing mandates on individual plans and allowing private insurers to offer low cost health policies to the public, as is done in other states.

South Carolina

As part of the Deficit Reduction Act of 2005, Congress allowed states to experiment with Health Savings Account (HSA) programs to save money in their Medicaid programs. Called Health Opportunity Accounts (HOA), these are designed to allow individuals to direct their benefits and give Medicaid recipients more control over their health care spending and decision making.

In 2008, South Carolina established a pilot HOA program in one county, limited to just one thousand people. In each recipient's HOA the state Medicaid program places up to \$1,000 per child and \$2,500 per adult per year. If all this money is spent on health services before the end of the year, the recipient is responsible for paying 10% of further costs, up to \$250 per adult and \$100 per child. Thus, under the program a single parent with one child can pay no more

⁶¹ "The Massachusetts health plan, The good, the bad, and the ugly," by David Hyman, Policy Analysis, The Cato Institute, June 28, 2007.

⁶² "The Price of Romney Care," Editorial, *The Wall Street Journal*, July 29, 2008.

⁶³ Ibid.

than \$350 in total medical expenses for the year.⁶⁴

The program includes counseling for participants, consumer protections and measures for provider performance and patient satisfaction. State Medicaid officials monitor the HOA balances, provide advice and guidance, and stand ready to intervene if low-income patients are not receiving adequate health services, or are unhappy with their current provider.

Unlike top-down state mandated program, South Carolina's Medicaid program based on individual accounts and patient control over benefits is proving successful in managing costs and providing poor and indigent residents with health care coverage.

Rhode Island

In an effort to place a cap on Medicaid spending, Rhode Island officials have asked the federal government for a waiver to give state administrators total control over their state's program, with no oversight from Washington D.C. The basis of the plan is an increased use of managed care, coupled with price controls in the form of cuts in reimbursements for providers and pay-for-performance schemes for physicians.⁶⁵

For fiscal 2009, Rhode Island plans to raise the income threshold for low-income parents to receive health care, as well as increasing monthly premiums for at least 7,800 low income families. It is too early to assess the program, though state-imposed price controls and restrictions on doctors have a poor track record of providing affordable care or of reducing total health care costs.

Indiana

The Healthy Indiana Plan started in January 2008 and was limited to the first 120,000 applicants who had had no health care insurance for at least six months and who earned less than 200% of the FPL. The program had two parts, comprising a high deductible insurance plan and a state-funded HSA. To limit the financial burden on families, individuals contribute no more than 5% of gross family income to the HSA.⁶⁶

As of March, 2009, Indiana had enrolled a total of 49,000 residents and had reached its allowable limit of 34,000 childless adults.⁶⁷

Indiana received a Medicaid waiver so that if the program runs out of money, the state can shut it down.⁶⁸ It is funded by a \$.44 per pack increase in the state cigarette tax.

Florida

The Florida legislature passed Empower Care in 2006. This is a five-

⁶⁴ "State Legislation and Action on Health Savings Accounts and Consumer-Directed Health Plans, 2004-2008, South Carolina," National Conference of State Legislatures (NCSL), October 2008.

⁶⁵ "Rhode Island Seeks Medicaid Overhaul, Cap on Spending," *amednews.com*, November 17, 2008.

⁶⁶ "Healthy Indiana Plan, State Launches Coverage for Low-Income Hoosiers," *The Evansville Courier Press*, January 1, 2008.

⁶⁷ "Healthy Indiana Plan Achieves Milestone," *Muncie Free Press*, March 11, 2009.

⁶⁸ "HHS Approves Medicaid Waiver to Create New Indiana Health Plan for Uninsured Hoosiers," press release, U.S. Department of Health and Human Services, at www.hhs.gov/news/press/2007pres/12/pr20071214a.html.

county pilot program to control rising Medicaid spending by changing from a defined benefit to a defined contribution plan using managed care programs which stress wellness and preventative care. These five counties contain 9% of all Florida Medicaid recipients, with 84% of that number being children and parents and 16% disabled individuals.⁶⁹

The program was budget-neutral the first year, although the willingness of providers to participate was limited by low reimbursement rates.⁷⁰ Fee-for-service doctors and provider networks will have their fees capped on September 1, 2009.⁷¹

The state experienced an overall 7.2% reduction in Medicaid spending the second year, fiscal 2008, with an actual cost per recipient of \$282 per month, compared to the original budget estimate of \$328 per month.⁷² Total state-wide implementation of the program is scheduled for 2011.

Louisiana

The goals of Louisiana's new Medicaid plan are to control rising costs while improving health outcomes. The proposed method for accomplishing these goals is the latest variation of managed care, the Medical Home concept.⁷³ With a Medical Home, patients are assigned a primary care doctor who then oversees all aspects of that person's health care, including specialty referral and wellness programs. Providers are reimbursed on a defined contribution plan rather than a fee-for-service.

The poor will be totally subsidized and those people with incomes between 200-350% of the FPL can buy into the program on a sliding scale. To date, there is no published funding mechanism.⁷⁴

As of March, 2009, the plan was under review by the Center for Medicare and Medicaid Services (CMS).⁷⁵

Other States

Because of the economic recession, all states will undoubtedly be reviewing cost saving measures in their health care budgets for fiscal years 2009 and 2010. A number of states have already instituted minor changes to their Medicaid programs.

The following is a list of the recent money-saving changes to individual state Medicaid plans as of July 2008.⁷⁶

New Jersey - cutbacks in paying hospitals for providing uncompensated

⁶⁹ "Summary of Florida Medicaid Reform Waiver, Early Findings and Current Status," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2008, at www.kff.org/medicaid/7823.cfm.

⁷⁰ Ibid.

⁷¹ <http://ahca.myflorida.com.medical/html>.

⁷² "An Evaluation of the Pilot Project to Reform Florida's Medicaid Program," by Michael Bond, The James Madison Institute, Backgrounder No. 56, July, 2008, at www.jamesmadison.org/article.php/641.html?PHPSESSID=5c923934f3e35f4899.

⁷³ "Louisiana Governor Jindal Unveils 'Louisiana Health First' Medicaid Overhaul Plan," Kaiser Daily Health Policy Report, November 18, 2008, at www.kaisernetwork.org.

⁷⁴ Ibid.

⁷⁵ "Medicaid Reform Efforts Underway in Louisiana and Rhode Island," www.newsrx.com/health-alert/3510./html.

⁷⁶ "Washington Legislative and Regulatory Outlook," by Andrew B. Bressler, Bank of America, July 2008, page 11.

care.

California - decreased benefits and eligibility for recipients, and a tightening of state price controls by imposing a 10% reduction in payments to doctors.

Arizona - keeping state Medicaid rolls current by requiring recipients to renew their applications more frequently.

Maine - a new \$25 enrollment fee for low income parents.

Nevada - increase in the co-payments recipients pay when they receive medical services.

In addition, state officials in **Illinois, Minnesota, Florida, New Hampshire** and **Virginia** are using their states' Medicaid price control mechanisms to delay, freeze or otherwise reduce payments to doctors.

New Federal Plans for Medicaid

Realizing Medicaid costs are unsustainable, Congress has passed several changes to the program in the last few years. The Deficit Reduction Act of 2005 allowed ten states to set up five-year demonstration programs utilizing Health Opportunity Accounts (HOAs).⁷⁷

HOAs are similar to Health Savings Accounts (HSAs), which are proving to be successful in giving individuals more control over their health care spending and decision making.⁷⁸ With HOAs, the states receive federal matching funds to fill individual accounts up to \$1,000 per eligible child and \$2,500 per eligible adult. If the money in the HOA are depleted, then standard Medicaid takes over to provide catastrophic health coverage. In addition, if a person becomes ineligible for Medicaid, that individual is allowed to keep up to 75% of the money in his HOA for up to three years to buy private health insurance.

Critics of HOA Medicaid programs say people will forego needed medical care in order to save money in their account. This has not been the case with HSAs in the private market. Experience shows that HSA holders receive just as much health screening and preventive care as the general insured population.⁷⁹ HOA holders have the added incentive that they have not placed their own money in their account, but have received it from a government program, meaning they have even less reason to leave their health benefit unused.

To date, South Carolina is the only state reporting an HOA program, as discussed above.

In another federal reform, officials at the Center for Medicare and Medicaid Services (CMS), the government agency that controls Medicare and Medicaid, have decided to let disabled recipients choose how to use their own Medicaid benefits. This has the potential to gain huge savings for the government, while giving disabled people more control and greater personal responsibility. This self-directing mechanism is an important way policymakers can increase home care and decrease costly institutional care, while realizing significant savings

⁷⁷ "Opportunities for State Medicaid Reform," by John C. Goodman, et al., National Center for Policy Analysis, Policy Report No. 288, September 28, 2006, at www.ncpa.org/pub/st288.

⁷⁸ "Health Care Reform that Works: An Update on Health Savings Accounts," by Roger Stark, MD, Washington Policy Center Policy Brief, August, 2008, at www.washingtonpolicy.org/Centers/health-care/policybrief/HSAUpdate2008.pdf.

⁷⁹ Ibid.

for taxpayers.⁸⁰

For example, in fiscal 2005, Medicaid provided for 1.7 million recipients in nursing facilities at a cost of \$26,234 per patient per year. During the same year, Medicaid funded 1.2 million disabled people who received care in their homes at a cost of only \$4,510 per patient per year.⁸¹ Clearly, home care is far more cost effective than institutional care for disabled people.

Another proposed solution is the concept of federal Medicaid block grants to the individual states. Although this idea has been around for years, it gained popularity with the passage of welfare reform in 1996.⁸² Block grants would eliminate open ended federal funding, would limit federal taxpayer exposure, and would make more states financially responsible. To date, no comprehensive federal legislation has been passed to give Medicaid block grants to the states.

Can Medicaid be Reformed?

At current rates of spending increase, Medicaid spending will double from fiscal 2008 levels in nine years, that is, by fiscal 2017.⁸³ At an average growth rate of eight percent a year, Medicaid is the fastest growing federal entitlement program.⁸⁴ The Congressional Budget Office estimates that, without changes made to current policies, the Medicaid program alone will comprise almost six percent of the nation's Gross Domestic Product by 2017.⁸⁵

Medicaid directors from all the states met in the fall of 2007 to discuss ways to control rising costs. There was broad agreement that the economic climate was not only deteriorating, but that methods used to save money in past recessions will not work today.⁸⁶ For example, drugs for dual Medicare-Medicaid recipients are now covered by Medicare Part D. Since Medicaid no longer pays for these drugs, there would be no additional savings to the Medicaid program.

Obviously, the country cannot afford to pay for Medicaid based on its present structure. Reform will be necessary in order to avoid the program's financial collapse.

Congress actually passed a fairly broad Medicaid reform package in 1995. The bill included block grants to the states, gave states more individual control, and eliminated the program as a federal entitlement. President Clinton vetoed the bill, although a year later he signed a similar, and very successful, reform of welfare entitlements.

At the time congressional Republicans paid a heavy price politically and were accused of being uncaring and wishing to deny needed health care for poor Americans. Follow-up analysis, however, shows that had the 1995 reform bill

⁸⁰ "Consumer Direction in Medicaid and Opportunities for States," by Dennis G. Smith, The Heritage Foundation, Web Memo # 2129, November 13, 2008, at www.heritage.org/research/health-care/wm2129.cfm.

⁸¹ "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department on Health and Human Services, November 1, 2008.

⁸² "Handbook on State Health Care Reform," by John C. Goodman, National Center for Policy Analysis, Dallas, 2007, page 122.

⁸³ "Federal Medicaid Payments," CBO March 2008 Baseline: Medicaid, Congressional Budget Office, March 2008, at www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf.

⁸⁴ "The Budget and Economic Outlook, 2007 - 2017, An Update," Congressional Budget Office, August 2007, page 9, at www.cbo.gov/ftpdocs/85xx/doc8565/08-23-Update07.pdf.

⁸⁵ *Ibid*, page 3.

⁸⁶ "Current Issues in Medicaid: A Mid-FY2008 Update Based on a Discussion with Leading Medicaid Directors," Report 7741, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January, 2008, at <http://www.kff.org/medicaid/7741.cfm>.

been signed into law, the Medicaid program would be on a much sounder financial footing today.

The Success of Welfare Entitlement Reform

In 1996, Congress passed major welfare reform legislation. The long-standing entitlement of Aid to Families with Dependant Children (AFDC), which functioned much like Medicaid, was replaced by the Temporary Assistance to Needy Families (TANF) program. The TANF plan implemented a number of major reforms: it ended automatic entitlement benefits, it set a five year limit on participation, it established a work requirement, it gave states federal aid in the form of flexible block grants, and it gave states greater control over their welfare programs.

The success of the TANF reform is dramatic. Welfare rolls have fallen by 50% and poverty rates have decreased across every demographic group, including children.⁸⁷ As a result, the poverty rate in 2005 was at a 17 year low.⁸⁸

Congress had initially included Medicaid reform in the 1996 welfare reform legislation, but it was eliminated because President Clinton threatened to veto the whole bill if the Medicaid provision was not removed.

TANF did eliminate Medicaid benefits to many immigrants. Interestingly enough, the number of immigrants with health insurance then actually rose, without the states adding that population group to their own Basic Health Care rolls.⁸⁹ Higher insured rates among immigrants reflected a reverse “crowd out” effect, encouraging individuals to secure their own private health insurance independently once they no longer qualified for a tax-subsidized program.

Many Medicaid reform proposals have been recommended down through the years. Some of these, such as negotiating discounts for services, increasing provider fees to keep patients out of emergency rooms, and controlling drug costs, do not address the underlying problem of funding a broad health care entitlement.⁹⁰

Similarly, there is virtually no evidence that any of these ideas would significantly impact the cost or the effectiveness of Medicaid. On the other hand, such initiatives as HOAs or HSAs, pursuing fraud aggressively, tightening eligibility requirements, and using block grants to states, have been shown to be effective in controlling costs in both the health care and welfare policy areas.

Freezing funding at fiscal 2005, or even fiscal 2007, levels, restoring eligibility requirements to the original 1965 level, implementing federal block grants to states and allowing recipients to use individual HSA-style health accounts would bring meaningful, proven reform to the beleaguered Medicaid program.

⁸⁷ “Healthy Competition,” by Michael F. Cannon and Michael D. Tanner, 2nd edition, The Cato Institute, Washington, D.C., 2007, page 108, and “Poverty Status of People by Family Relationship, Race, and Hispanic Origin, 1959-2005.” Table 2, Historical Poverty Tables, U.S. Census Bureau, at www.census.gov/hhes/www/poverty/histpov/hstpov2.html.

⁸⁸ Ibid.

⁸⁹ “Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population,” by George J. Borjas, Economic Research Initiative on the Uninsured, Working Paper no. 16, May 2003, pages 31-32.

⁹⁰ “Medicaid Empire: Why New York Spends so Much on Health Care for the Poor and Near Poor and How the System Can Be Reformed,” by John C. Goodman, et al., National Center for Policy Analysis Policy Report No. 284, March, 2006, at www.ncpa.org/pub/st284.

Recommendations for Reforming Medicaid

- Health Savings Accounts for Recipients
- Pursue Fraud Aggressively
- Tighten Eligibility Requirements (At least back to the original 133% of the FPL)
- Block Grants to the States
- Freeze Funding at 2005 or even 2007 Levels

Conclusion

The economic slowdown has already caused an increase in unemployment and a slowing in the yearly growth of the tax base. As unemployment rises, the growth of Medicaid is predicted to increase. Yet there will be less tax revenue to support this increased enrollment.

Logic would say that state policymakers should slow down the expansion of their Medicaid programs, although the reverse seems to be happening. In 2008, officials in 42 states expanded eligibility for tax-funded long term care benefits. One-third of the states, including Washington, expanded their Medicaid managed care programs or reduced their baseline eligibility requirements. For 2009, 41 states are on track to further expand their long term care programs. All of the proposed Medicaid expansion is in addition to likely increases in state spending for unemployment benefits and an expansion of the children's health care program, S-CHIP, by many states.

The vast majority of states face substantial budget deficits in the next fiscal year. This fact, coupled with the intensive push toward government controlled, universal health care in Washington D.C., makes the future of the Medicaid program uncertain. It is likely in the next few years, we will see a major policy shift toward national socialized medicine, which will take the place of all other government programs outside of Medicare and the Veterans Administration systems. The new federal administration, as well as Congress, are already laying the groundwork for a massive additional government intervention into health care. It is likely state legislators, including those in Washington, will seek opportunities to off-load their Medicaid costs onto the federal government.

The tragedy is that after more than 40 years of this government program, there is no evidence that Medicaid has improved health outcomes for either children or adults enrolled in the program.⁹¹ Medicaid, like any entitlement that offers services for free, has encouraged over utilization of health care resources. When services appear to be "free," the natural health care market has no ability to place a true value on that service and no way to know if limited resources are being used efficiently.

Limited public safety net programs will always be needed to provide health care for the poorest and most vulnerable people in our society. However, the bloated and expanding Medicaid entitlement program, as it is presently structured, is not sustainable. Only thorough reform, based on changes that have proven successful in other entitlement programs, will ensure that Medicaid is placed on a sound, long-term financial basis, so it remains to provide vital health services for low-income families.

⁹¹ "Does Public Provided Health Insurance Improve the Health of Low-Income Children in the United States?," by Robert Kaestner, et al., NBER Working Paper no. 6887, January 1999, page 1.

Addendum

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009, also known as the “economic stimulus bill.” It includes a substantial financial boost to the existing Medicaid program with an infusion of \$87 billion. This represents a 6.2% increase in funds to all states. The increase is retroactive to enrollees from October 1, 2008 and extends to December 31, 2010.⁹² Washington State’s share of this money is to be \$2.06 billion.

Also included in the new law are \$3.2 billion for additional state fiscal relief related to Medicaid, \$1.3 billion to extend a program that provides Medicaid coverage to individuals transitioning from welfare to work, and \$460 million to further subsidize disproportionate share hospitals.⁹³

It can be argued that these funds will not stimulate the economy. On the other hand, they will definitely expand Medicaid in a fashion that will be virtually impossible to reverse and will push states to legislate unsustainable future budgets.

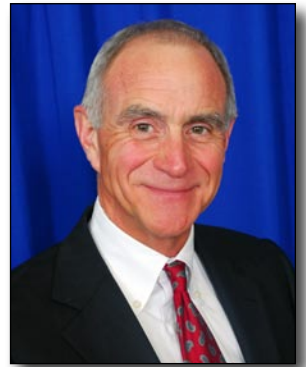
⁹² Public Law 111-5, “The American Recovery and Reinvestment Act of 2009, signed February 17, 2009, at www.thomas.gov/home/approp/app09.html.

⁹³ Ibid.

About the Author

Dr. Roger Stark is a health care policy analyst with Washington Policy Center. He is the author of the 2007 book *Health Care in the U.S. Today: Problems and Solutions*, as well as numerous studies on health care policy.

Dr. Stark graduated from the University of Nebraska College of Medicine and completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. Dr. Stark has been a member of many local and national professional societies. He currently serves on the Board of the Washington Liability Reform Coalition, the Governing Board of Overlake Hospital, and is an active member of the Woodinville Rotary.



Published by Washington Policy Center

Chairman
President
Vice President for Research
Communications Director

Greg Porter
Daniel Mead Smith
Paul Guppy
John Barnes

If you have any comments or questions about this study, please contact us at:

Washington Policy Center
PO Box 3643
Seattle, WA 98124-3643

Online: www.washingtonpolicy.org
E-mail: wpc@washingtonpolicy.org
Phone: 206-937-9691

Nothing in this document should be construed as an attempt to aid or hinder the passage of any legislation before any legislative body.

© Washington Policy Center, 2009

