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POLICY BRIEF

National Health Care Reform and the New Medicaid

by
Roger Stark, MD, FACS
Health Care Policy Analyst

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Key Findings

1. Limited public safety net programs will always be needed to provide health care for the poorest and most vulnerable people in our society.

2. After more than 40 years, there is no evidence Medicaid has improved health outcomes for the vast majority of either children or adults enrolled in the program.

3. Medicaid spending is now the fastest growing line item in nearly every state in the country.

4. Medicaid is unsustainable. At the current rate of spending increase, Medicaid spending will double compared to fiscal 2008 levels in nine years, that is, by fiscal 2017.

5. Medicaid costs will explode as a result of recent health care reform legislation. Eventually, the federal government will have only three choices, all of which are bad: run huge budget deficits, raise taxes, or ration medical care by limiting funding.

Introduction

Significant federal health care reform legislation, the Patient Protection and Affordable Care Act or PPACA,[1] passed last spring with narrow partisan support and substantial bipartisan opposition. A social entitlement program of this magnitude has never passed Congress without broad support from both major political parties. The law remains controversial, with 20 states filing suit against it in federal court.

The Congressional Budget Office (CBO) is the non-partisan organization that determines the cost of proposed legislation. Although the CBO has subsequently adjusted the cost of the new health care reform law upward, it initially scored the bill at approximately $1 trillion.[2] Four to five percent of the cost was for administrative fees (around $40 billion) and the remainder was evenly divided between paying for subsidies in the new insurance exchange and paying for a newly-expanded Medicaid program.

Almost one half of the cost of national health care reform will pay for creating a new, greatly-expanded Medicaid program. It is worth examining this new program and how it will relate to existing state Medicaid programs. It should be noted that the new law uses traditional Medicaid to create an entirely new entitlement. The eligibility requirements and funding mechanisms for the new Medicaid will be totally different from the existing program.

The Current Medicaid Program

The current 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 to taxpayers. From the beginning, a link was established between Medicaid eligibility and the welfare program, Aid to Families with Dependant Children (AFDC).[3] The current Medicaid program 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 the current Medicaid program 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 percent in federal money and 43 percent in state funds.[4]

[1] http://www.ncsl.org/documents/health/ppaca-consolidated.pdf
[2] http://www.cbo.gov/doc.cfm?index=11355
[3] "Medicaid Legislative History, 1965-2000", The Kaiser Commission on Medicaid and the Uninsured, Appendix 1, p 175, 2000.
[4] "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.

Medicaid spending is now the fastest growing line item in nearly every state in the country. In 2008, Medicaid spending accounted for 21 percent of the average state budget and 20 percent in Washington state.[5] Total spending on Medicaid in Washington State was $6.3 billion for fiscal 2008.[6] The contribution from Washington State taxpayers was 48 percent of the total which is higher than the national average of 43 percent.

According to the National Association of State Budget Officers, Medicaid 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 2008, Medicaid expenses for federal and state governments combined were $339 billion. This number is projected to reach $523 billion by 2013, a 54 percent increase in just five years.[7]

Medicaid spending is the fastest growing line item in nearly every state in the country. According to the National Association of State Budget Officers, Medicaid 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

Medicaid spending on the current program will double by 2017.[8] At an average growth rate of eight percent per year, Medicaid is the fastest-growing federal entitlement program.[9] The non-partisan Congressional Budget Office estimates the Medicaid program alone will account for almost six percent of the nation's Gross Domestic Product by 2017.[10]

The Original Medicaid Program

The Medicaid entitlement commits the federal government to providing health services, regardless of cost, to all U.S. residents who meet the eligibility requirements.[11] When created in 1965, eligibility was defined as:

1. All children in families with incomes of less than 133 percent 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

Under Medicaid, Washington D.C., provides broad national guidelines with 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

[5] http://www.nasbo.org/Publications/StateExpendatureReport/tabid/79/Default.aspx
[6] http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=49.
[7] "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.
[8] "Federal Medicaid Payments," CBO March 2008 Baseline: Medicaid, Congressional Budget Office, March 2008, at www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf.
[9] "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.
[10] Ibid, page 3.
[11] "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/MedicaidMilestones.pdf.

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 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.

The Expansions of Medicaid Since Enactment

Since its inception, Medicaid 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.[12] The federal legislative language also shows a shift from "allowing" states voluntarily to increase eligibility and benefits to "requiring" states to expand the program. The result has been a significant increase in the share of state budgets claimed by the federal program.

The federal legislative language also shows a shift from "allowing" states voluntarily to increase eligibility and benefits to "requiring" states to expand the program. The result has been a significant increase in the share of state budgets claimed by the federal program.

The shift by federal officials to impose 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 Dependant 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[13], 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 the passage of Title XXI of the Social Security Act, enacted as part of the Balanced Budget Act of 1997. The bill created the State Childrens' 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 percent of the federal poverty level (FPL).

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[12] "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.

[13] 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.

The law 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 percent of the FPL, and nineteen states cover up to 300 percent of the FPL through the S-CHIP plan.[14] The Washington legislature passed legislation in 2009 that would expand state-subsidized health care to 300 percent of the FPL, which is $64,200 for a family of four. The state also now offers non-subsidized health insurance to children of families making more than 300 percent of the FPL.[15]

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.

One major result of this expanded government coverage is to crowd out private insurance coverage, as well as an increased tax burden for state taxpayers. 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.

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.[16] After more than 40 years, it remains an open question 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. The actual cost in the first year was double that figure, $1 billion. By 1970, the cost of the program had expanded by 500 percent to $5 billion, a period in which inflation increased by only 23 percent.[17]

The Medicaid program has never lived up to the promises of its advocates in the area of cost containment in health care.

By 2007, total cost (state plus federal spending) was a staggering $336 billion.[18] Interestingly, these numbers are probably low, since only two-thirds of potential Medicaid recipients are signed up at any one point in time.[19]

Medicaid now represents almost 15 percent of the $2.1 trillion in total annual healthcare spending in the United States. In 2007, this single program accounted for fully 7 percent of all federal spending.[20] On its own terms, Medicaid has been a failure in controlling the rising cost of health care services.

Over the next ten years its cost is projected to grow at a rate of almost 8 percent per year, faster than the growth rate of both health care spending and the

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[14] "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.
[15] Bill Summary at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2128year=2009.
16 "Medicaid Politics and Policy, 1965-2007," by David G. Smith and Judith D. Moore, Transaction Publishers, New Brunswick, 2008, pages 375-376.
[17] Ibid.
18 "2007 State Expenditure Report," National Association of State Budget Officers (NASBO), Fall 2008, at www.nasbo.org/Publications/PDFs/FY07%20State%20Expenditure%20Report.pdf.
[19] "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.
[20] "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.

economy in general.[21] The table below shows the national figures for all Medicaid recipients by category and their per-person costs for FY 2005.[22]

Medicaid Recipients by Category and their Per-Person Costs for FY 2005

Category	% of Total Recipients	Cost per Recipient/Year
Children	51%	$1,667
Adults	24%	$2,475
Aged	9%	$13,675
Disabled	16%	$13,846
Total	100 %	

Children represent the largest number of Medicaid beneficiaries, yet 87 percent of funding is spent on just 25 percent of recipients – the disabled and elderly – 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 percent increase from the 7.0 million recipients in 2004.[23] Program officials found that for fiscal 2009, a full one-third of Medicaid spending ($114 billion) will be for the disabled. With the aging of the U.S. population, they expect this amount to reach $1.7 trillion in ten years.[24]

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.

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.

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.

[21] Ibid.
[22] "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.
[23] "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.
[24] Ibid. See Note 29.

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 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.[25]

Because of the current economic recession, Washington state has just cut $112.8 million from its Medicaid program. [26] The situation becomes even worse for the next biennium when $521 million will need to be cut from the program.

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 percent of adults and 27 percent of children in Medicaid already had private insurance at the time they enrolled.[27] 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.[28]

According to state program managers, Medicaid is anything but a smooth and efficient program.

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.[29] As the government steps in with a mandatory program, these private entities reduce their charitable services in the area of health care, leaving more burden on taxpayers and reducing voluntary medical aid to the needy.

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.[30] 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

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[25] "Reforming the Medicaid Disproportionate Share Hospital Program," by Teresa A. Coughlin, et al., Health Care Financing Review 22, no. 2, Winter 2000.
[26] http://www.dshs.wa.gov/mediareleases/2010/pr10088.shtml.
[27] "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.
[28] "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.
[29] "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.
[30] "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.

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 percent 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 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.[31] In all, Medicaid's low reimbursement rates contribute greatly to the inefficient allocation of health care services in the practice of American medicine.

The Health Care Reform Law's Changes to the Current Medicaid Program

Although the newly-expanded Medicaid program does not begin until 2014, the existing program will undergo a number of changes created by the new health care law.

Starting in 2011, Medicaid will prohibit payment to providers for services related to health-acquired conditions. In other words, Medicaid will not pay for treating medical complications that arise during treatment.

The government will increase the mandatory Medicaid drug rebate from 15.1 percent to 23.1 percent this year. Hence drug manufactures will pay an additional 8 percent to the states for drugs sold through the Medicaid program. The federal government will also increase the funding and the role of the Medicaid Payment and Access Commission to manage the care Medicaid enrollees receive.

Starting in 2011, Medicaid will prohibit payment to providers for services related to health-acquired conditions. In other words, Medicaid will not pay for treating medical complications that arise during treatment. This means doctors will have an even stronger disincentive to begin treatment of Medicaid patients. If anything goes wrong with treatment, or new illnesses arise during treatment, the doctor will receive no payment for his services.

Medicaid will also begin to change the way health care is administered. The Center for Medicare and Medicaid Services (CMS), through Medicaid, will provide funds to establish mandatory medical homes for patients, which are the latest variation of health maintenance organizations (HMOs). Long-term care in non-institutionalized settings and community-based support for people with disabilities will receive more money.

State Medicaid programs will increase payments for primary care for two years only, starting in 2013. This increase will be funded exclusively by federal taxpayers.

The New Medicaid

The national health care reform law greatly expands and changes the Medicaid program starting in 2014. This "new" Medicaid will provide health insurance to anyone in the country who earns less than 133 percent of the FPL and is under age 65. The FPL is currently $10,830, so any individual making less than $14,400 will be eligible. For a husband and wife, 133 percent of the FPL is $19,400.

[31] "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.

The details have not been worked out, but presumably, the new Medicaid will be administered through the existing state Medicaid agencies. Mandatory rules, regulations and oversight, however, will come from the federal government.

Instead of the fifty-fifty state-federal cost sharing, the new program will be paid for exclusively by federal taxpayers for the first three years. From 2017 until 2020, the percent paid by state taxpayers will gradually increase from zero to ten percent, with this ten-ninety percent (state-federal) split extending indefinitely. Of course, state taxpayers are the same people who pay federal taxes, so this will be a huge tax increase on everyone.

States will continue to have the choice of opting out of Medicaid. However, state legislators will be even more hesitant to drop out of Medicaid simply because the vast majority of funding (100 percent initially, then 90 percent indefinitely) will come from the federal government and will not theoretically impact state budgets. The temptation for state lawmakers is they will get to distribute benefits, without incurring the political responsibility of raising taxes to pay for them.

The temptation for state lawmakers is they will get to distribute benefits, without incurring the political responsibility of raising taxes to pay for them.

The number of new enrollees in Medicaid is estimated to range from 14 to 23 million people.[32] The new health care reform law mandates that everyone in the country must have health insurance. Because this individual mandate may cause previously uninsured people to "come out of the woodwork", this estimated range of up to 23 million people may be too low.

Access to health care is currently limited in Medicaid because providers cannot pay their overhead with such low reimbursement rates. The new law law does not allow for an increase in physician pay except for primary care on a limited basis. Therefore, as demand explodes after 2014 with up to 23 million new patients enrolled in the new Medicaid, access to health care will become dramatically worse for Medicaid patients.

States with a low participation rate in the existing Medicaid program (for example, Texas and Alabama) will potentially have a higher participation rate in the new program. Conversely, states such as Massachusetts that have a low uninsured rate will see a smaller percentage of new participants. Consequently, the impact on state budgets will be less for those states that enroll a higher percentage of people in the new Medicaid for which the federal government pays 90 to 100 percent of the costs.

States could start enrolling childless adults in Medicaid after April 1, 2010. Funding for these enrollees will be set at the original fifty-fifty state-federal match rate.

Overall costs of the Medicaid expansion are estimated to be $445 billion from federal taxpayers and $21 billion from state taxpayers between 2014 and 2019. This $466 billion represents approximately half of the overall estimated future costs of the new health care reform law.

The Impact of the New Medicaid on Washington State

The complexity of the new law means no one knows exactly how many people will enroll in the new Medicaid. There are 60 million people nationwide enrolled in the current Medicaid program, which means Washington state's 1.2 million people represent 2 percent of the total. Estimates of new enrollees

[32] Andrew M. Sisko *et al.*, "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs*, Vol. 29, No. 10 (2010), at http://content.healthaffairs.org/cgi/reprint/hlthaff.2010.0788v1 (October 4, 2010).

nationally range from 14 to 23 million. Hence 2 percent of estimated new enrollees would be 280,000 to 460,000 people in Washington state.

The 1.2 million enrolled in Washington's current Medicaid program cost taxpayers $6.2 billion annually (state taxpayers pay $3.1 billion and federal taxpayers pay $3.1 billion). This works out to approximately $2,583 of state taxpayer dollars per recipient and a total cost (federal plus state) of $5,167 per enrollee.

The new health care law is written so that federal taxpayers cover the entire cost of the new Medicaid program's patients for the first three years and states ultimately pay 10 percent of the costs. Washington state taxpayers would therefore be required to pay $5,167 times 10 percent times 280,000 (or 460,000) per year which equals a range of $145 million to $242 million. For a ten year period, Washington state taxpayers would be obligated to pay $1.45 billion to $2.42 billion.

If the state/federal ratio for funding new Medicaid patients reverts to the fifty-fifty split as it exists now, Washington taxpayers would be required to pay $5,167 times 50 percent times 280,000 (or 460,000). This would equal a range of $723 million to $1.2 billion per year, and $7.23 billion to $12 billion over ten years. Of course, state taxpayers are also federal taxpayers, so Washington state taxpayers will be required to help pay the entire cost of Medicaid expansion, or $14.5 billion to $24 billion over a ten year period.

Another tragic consequence of Medicaid is it has discouraged both job advancement and entrance into the job market for thousands of people. With each increase in income, for example by getting a new job, low-income workers face the risk of losing their Medicaid health benefits.

Policy Analysis: How Medicaid Distorts the Health Care Market

From 1999 to 2003, the percentage of physicians accepting all new Medicaid patients dropped from 48.1 percent to 39.4 percent, and those who stopped accepting new Medicaid patients completely increased from 26.4 percent to 30.5 percent.[33] The unfortunate, but predictable, consequence of low doctor reimbursement is a decrease in access to health care for Medicaid recipients.

When a government entitlement like Medicaid competes with the free market, there are a number of broad economic consequences. Because of cost shifting under Medicaid, consumers with private insurance are burdened with an additional cost of 10 percent to 15 percent.[34] The result is a government health care program that actually increases the number of uninsured, because some people are forced to drop their private coverage as it becomes unaffordable. If the 10 percent to 15 percent in costs added by the Medicaid program were removed, millions of people who are currently uninsured would be able to afford private coverage.

Another tragic consequence of Medicaid is it has discouraged both job advancement and entrance into the job market for thousands of people. With each increase in income, for example 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 percent to 75 percent of private long-term insurance benefits duplicate Medicaid

[33] "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.
[34] "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.

benefits, creating a strong incentive for people to drop their private coverage.[35] Current estimates reveal that Medicaid has discouraged 65 percent to 90 percent of seniors from purchasing private long-term insurance.[36]

Policy Analysis: 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 to support this concept.

In fact, after more than 40 years, there is no evidence that Medicaid has improved health outcome for adults or children,[37] (except for very specific populations such as HIV/AIDS patients) nor is there evidence that increasing Medicaid spending has resulted in better health care for the poor.[38] 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.[39]

Because Medicaid is a third party payer system, it is a fundamental part of the problem of health care access and affordability in the U.S.

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 percent 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.[40] If over-utilization in Medicaid is similar to Medicare, the amount of overuse could be as high as $50 billion per year.[41] Government exists to provide a vital safety net for its most vulnerable citizens, so the Medicaid program will have to change if is to survive financially.

Recommendations for Reforming Medicaid

At the current rate of spending increase, Medicaid spending will double compared to fiscal 2008 levels in nine years, that is, by fiscal 2017.[42] At an average growth rate of eight percent per year, Medicaid is the fastest growing federal entitlement program.[43] 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.[44] The new

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[35] "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.
[36] Ibid.
[37] "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.
[38] "Hospital Ownership and Public Medical Spending," by Mark Duggan, NBER Working Paper no. 7789, July 2000.
[39] "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.
[40] "Interdependence and Choices in Distributive Justice, The Welfare Conundrum," by Lee Anne Fennell, Wisconsin Law Review 235, 1994, pages 311-312.
[41] "Healthy Competition," by Michael F. Cannon and Michael D. Tanner, 2nd edition, The Cato Institute, Washington, D.C, 2007.
[42] "Federal Medicaid Payments," CBO March 2008 Baseline: Medicaid, Congressional Budget Office, March 2008, at www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf.
[43] "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.
[44] Ibid, page 3.

health care reform law's addition of 23 million more patients to the "new" Medicaid will only make this cost problem worse.

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 would not work today.[45] 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.

Initiatives as health savings accounts (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

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

Many Medicaid reform proposals have been recommended 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.[46]

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 health savings accounts (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.

Rather than compounding the existing Medicaid problems, the new federal health care law should be repealed. There is no logical reason to enlarge a bankrupt entitlement.

Recommendations for Reforming Medicaid

- Health Savings Accounts for Recipients
- Pursue Fraud Aggressively
- Tighten Eligibility Requirements (At least back to the original 133 percent of the FPL)

[45] "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.
[46] "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.

- Block Grants to the States
- Freeze Funding at 2005 or even 2007 Levels
- Repeal the New Health Care Law

Conclusion

The current Medicaid program is arguably the worst health insurance plan in the country. It has expanded massively beyond the original intent in 1965 and is now one of the two or three largest budget items for nearly every state. In spite of massive annual increases in spending, Medicaid chronically experiences budget-breaking costs. Expanding Medicaid, as the new health care reform law requires, will only compound these problems.

Like any entitlement program, Medicaid encourages over-utilization. The tragic irony is that because of low provider reimbursements, access for patients is severely limited. The number of doctors who are not seeing new Medicaid patients grows larger each year. All Medicaid patients, by definition, have health insurance, but just having health insurance does not guarantee one will receive health care services.

Like any entitlement program, Medicaid encourages over-utilization. The tragic irony is that because of low provider reimbursements, access for patients is severely limited. The number of doctors who are not seeing new Medicaid patients grows larger each year.

Likewise, the new health care law does not specifically provide for more physicians and nurse practitioners. The addition of 23 million new patients on the Medicaid rolls will massively compound the existing health care access problem for patients in the program.

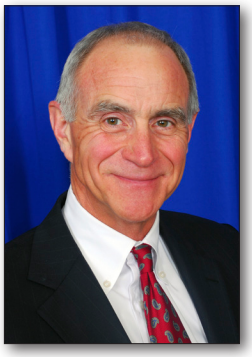
Another tragedy is that after more than 40 years, there is no evidence Medicaid has improved health outcomes for the vast majority of either children or adults enrolled in the program.[47] Medicaid, like any entitlement that offers services apparently for free, has encouraged over-utilization of health 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 allocated 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. Even though the new program will be funded by federal taxpayers, costs will explode as we have seen since 1965. The federal government will then have only three choices, all of which are bad: run huge budget deficits, raise taxes, or ration medical care by limiting funding.

A better plan is to repeal the reform law and stop the new, expanded Medicaid program before it starts. The government should then focus on meaningful reform to the current Medicaid, based on changes that have proven successful in other entitlement programs. This would ensure that Medicaid is placed on a sound, long-term financial basis, so it remains reliable enough to provide vital, dependable health services for low-income families.

[47] "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.

About the Author



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