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POLICY NOTE

State-based reforms for Medicaid

By Dr. Roger Stark, Policy Analyst, Center for Health Care March 2017

Key Findings

1. The Medicaid entitlement program has always been a partnership between state and federal taxpayers.
2. Federal lawmakers originally reasoned that if states paid for half of the Medicaid entitlement, state legislators would not want to burden state taxpayers with higher taxes and would therefore not expand Medicaid.
3. Instead, many state lawmakers look at Medicaid as a way to obtain "free" federal dollars and consequently, the program has dramatically expanded.
4. For this reason, Medicaid is not sustainable in its present form.
5. In anticipation of the repeal of Obamacare, state legislatures should plan for the best ways to reform their Medicaid programs.
6. Medicaid reform should include:
   - Enrollment freeze
   - Block grants
   - Work requirement
   - Co-pays
   - Return the eligibility requirement to 133 percent of the federal poverty level
   - Reform the health insurance industry
   - Aggressively eliminate waste, fraud, and abuse in the program
   - Resurrect the private insurance market for long-term care
   - Encourage and support home health care
7. The new Republican bill to repeal and replace the ACA is a good starting point for meaningful Medicaid reform.

Introduction

The Medicaid entitlement began in 1965 as a safety-net health insurance program for children of low-income families. It was originally financed by federal and state taxpayers using a fifty-fifty match formula. Federal lawmakers reasoned that if states were forced to pay for half of the entitlement, state legislators would not want to burden state taxpayers with higher taxes and would therefore not expand Medicaid by keeping it focused on helping the poor.

The exact opposite has occurred over the past 50 years. State lawmakers see Medicaid as a way to obtain more "free" federal dollars. Consequently, the program has dramatically expanded and is now one of the top three budget items for every state.

The Affordable Care Act (ACA), or Obamacare, compounded this state desire for federal dollars. The ACA offered 100 percent federal dollars to every state that expanded Medicaid to all low-income, able-bodied people 18 to 64 years of age. The 100 percent funding drops to 90 percent in 2020, with states paying the other 10 percent.[1]

Republicans now control the U.S. Senate, House, and the presidency. Repeal of the ACA, including the Medicaid expansion, is one of their legislative priorities. Congressional Republicans recently released a bill to repeal and replace the ACA. The bill would block grant Medicaid on a per-capita basis, would eliminate the Medicaid expansion in 2020 but continue the enhanced federal match at 80 percent for current expansion enrollees, and would give more control of the Medicaid program to the states. The bill would provide more funds to those states that did not expand Medicaid for use in hospitals that treat a high number of low-income patients.[2]

In anticipation of the passage of repeal legislation, this Policy Note presents the best ways states can adapt and reform their Medicaid programs to continue providing coverage for the neediest families.

The Medicaid program today

There are currently four groups of people receiving assistance through the traditional Medicaid program that began in 1965. These are the poor, the disabled, low-income mothers and children, and those individuals needing

1 "The Patient-Centered Solution; Our Health Care Crisis, How It Happened, and How We Can Fix It," by Roger Stark, MD, 2012.

2 "Text of the American Health Care Act," Fox News, March 6, 2017, at http://www.foxnews.com/politics/interactive/2017/03/06/text-american-health-care-act/

long-term care. Although mothers and children make up most of the beneficiaries, long-term care accounts for 70 percent of Medicaid dollars spent.

Medicaid expenditures are the fastest-growing budget item for virtually all states, even though the federal government supplies, on average, 57 percent of all Medicaid dollars spent in the legacy program and at least 90 percent of dollars in the new ACA-expanded Medicaid program. State reimbursement by the federal government for the traditional Medicaid program is based on the wealth of the state, with poorer states receiving a higher percentage match of federal money than wealthier ones.

Physician participation is voluntary, and doctor reimbursement from Medicaid has always been lower than that of any other payer, including Medicare. Consequently, an increasing number of physicians are withdrawing from the program, thus decreasing beneficiaries' access to health care by limiting their physician choices.

The cost of Medicaid was $1 billion in its first year, exploding to $545 billion by 2015. At the present rate of growth, the cost will be $900 billion a year by 2019. By the year 2030, government budget analysts estimate nursing home expenditures in Medicaid alone will equal the size of the entire Social Security program today.[3]

The Medicaid entitlement has resulted in a number of harmful consequences. First, it discourages work and job improvement for low-paid employees, since with increasing income workers lose their Medicaid benefits. It also encourages low-wage paying employers to not offer health benefits. They assume, or hope, taxpayers will provide those benefits. Medicaid also discourages private insurance companies from offering nursing-home policies, and this market shrinks farther every year.[4]

The real tragedy for people in Medicaid is the program provides no better medical outcomes than having no insurance. In 2008, Oregon lawmakers decided they had enough additional public money to put 10,000 more people on the state's Medicaid program. So, Oregon officials held a lottery that ultimately signed up 6,400 new Medicaid enrollees. A further 5,800 people were eligible for the program, but were not selected. People in this group had the same health and economic profile as the lottery winners, allowing researchers to make valid comparisons. This created the perfect test-case on the effectiveness of Medicaid in providing care. These 5,800 people became the control group in an objective, randomized health care study.

It turns out that being put on Medicaid does not improve health outcomes nor does it improve mortality statistics, compared to having no insurance coverage at all. The Medicaid group had no improvement in the important objective measurements of blood sugar levels, blood pressure, and cholesterol levels. The study did find that vaguely-defined "mental health" was improved, however this was done via subjective telephone interviews, not objective clinical data. For those few people requiring prolonged medical and hospital treatment, Medicaid did improve the financial status of those patients, because their medical bills were covered by federal and Oregon taxpayers.[5]

3 "National health expenditure fact sheet," Centers for Medicare and Medicaid Services, December 2, 2016, at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

4 "Medicare and Medicaid at fifty," by Roger Stark, MD, Policy Note, Washington Policy Center, September, 2015, at http://www.washingtonpolicy.org/library/doclib/Stark-Medicare-and-Medicaid-at-50.pdf

5 "The Oregon experiment – Effects of Medicaid on clinical outcomes," by K. Baicker, et. al., NEJM 2013; 368:1713-1722, May 2, 2013, at http://www.nejm.org/doi/full/10.1056/ NEJMsa1212321.

State lawmakers unfortunately have been caught in a vicious cycle in which the more they spend on the traditional Medicaid program, the more money they receive from the federal government because of the previous fifty-fifty match. The ACA required the federal government to pay for the entire Medicaid expansion for the first three years. Starting in 2020, states will pay 10 percent of the expansion costs. It is therefore no surprise that Medicaid is the largest, and fastest growing, budget item for almost all states in the country. Last year 1.8 million Washington residents, 25 percent of the state population, were enrolled in the Medicaid program.

Policy recommendations for states to reform and modernize Medicaid

The overall goal of reform

The most important first step to reforming the Medicaid program is to redesign it so it no longer functions as an unsustainable, open-ended entitlement. Welfare reform in the late 1990s was successful because it placed limits on how many years able-bodied people could expect to receive taxpayer support. Medicaid should provide health insurance on a temporary, safety-net basis, with a transition to sustainable private insurance within a defined, limited time period.

Supporters of Medicaid continually use examples of patients who are in desperate medical conditions as the reason to maintain the entitlement. Medicaid would have more money and more resources for the neediest patients if it were redesigned as a true safety-net program, as originally intended.

The belief in a single-payer, centrally-planned health care system for the U.S. is the hidden agenda for many people who support expanding Medicaid. Yet our country functions extremely well without universal government housing, or government-controlled food distribution. The goal of Medicaid reform should be the introduction of more free market ideas and personal choices, not more government.

1. Freeze enrollment

States should freeze enrollment at current levels. This would give states a reasonable budget limit on future spending and would allow states to plan future tax needs accordingly. As people transition out of the Medicaid program into sustainable private insurance, enrollment would obviously shrink by attrition alone.

2. Block grants and individual health insurance policies

States now essentially have an open checkbook from the federal government for Medicaid. The more a state spends on Medicaid, the more "free" money comes into the state because of the federal match. This is a huge incentive for even fiscally conservative state legislators to expand an unsustainable entitlement. The way to overcome this incentive is to give the states a fixed amount of federal money as a block grant, and then let the states manage the best way to spend it based on local conditions.

A further improvement of a single block grant would be individual grants for each patient enrolled in Medicaid. This money could be given to each person and they could then purchase individual insurance policies and health savings accounts (HSAs) in the private market. We already have the example of food stamps, which are given to individuals who then use them in the private food market. If given the opportunity, low-income people can shop just as carefully for health care as they do for food.

Officials in Washington state are currently promoting accountable care organizations (ACOs) to organize and treat Medicaid enrollees. ACOs are fundamentally the same as health maintenance organizations (HMOs) that were tried in the late 1980s. HMOs are very effective at controlling costs, but they do so by using a gate-keeper system where primary care providers limit patients from choosing and gaining access to specialty care. Medicaid patients are entitled to more control over their health care decisions than is provided by ACOs.

Allowing families to control their own health care dollars through subsidized HSAs or premium vouchers would financially reward enrollees for leading a healthy lifestyle and making smart personal choices. A policy based on choice would also show respect for low-income families, allowing them to be treated with equal dignity as others in the community.

3. Work requirement

Where applicable, Medicaid enrollees should have a work requirement. Like welfare, Medicaid should be viewed not as a permanent dependent lifestyle, but as a transition program to help low-income families achieve self-confidence, economic independence and full self-sufficiency.

A work requirement, which would include community service, would give enrollees a sense of ownership for their health care and would make Medicaid less of an entitlement.

4. Institute a co-pay

Like a work requirement, a co-pay would give ownership to enrollees. Even if they are paying a small amount, Medicaid would be less of an entitlement and would foster a sense of self-worth and self-confidence. The dollar amount of the co-pay is less important than the actual fact that enrollees are paying something toward their own health care.

5. Return the income requirement to 133 percent of the federal poverty level

The income requirement should be returned to the original 133 percent of the federal poverty level (FPL). Medicaid should not be a subsidized "safety-net" for middle-income people by encouraging those who can live independently to become dependent for their health care on a tax-subsidized entitlement program.

Medicaid has grown tremendously beyond the intent of the original law. State lawmakers should aggressively move to return the eligibility requirements back to the original 133 percent of the FPL. This would insure that Medicaid would have enough funds for the truly needy.

6. Reform the health insurance market

Special interest groups and well-meaning lawmakers have caused a tremendous distortion in the health insurance market. Specifically, dozens of insurance mandates have been added to every individual and small group plan sold. The ACA added ten benefit mandates that overlap with the mandates in most states, including the 58 mandates in Washington state.

For reform to be financially successful, the Medicaid entitlement needs low-cost alternatives.

Mandates add to the cost of health insurance. On average, each mandate adds 0.5 to 2.5 percent of the overall plan cost.[6] Plus, not everyone wants or needs each mandate. Why should a 27 year old, unmarried man pay for obstetrical coverage in his health insurance plan? Why should a non-drinker pay for alcohol rehabilitation? The ACA has not provided universal health insurance because young and healthy individuals are simply not willing to pay for costly plans that include benefits they don't want or need.

The solution for everyone, including Medicaid enrollees, is to deregulate the health insurance industry, eliminate costly mandates and allow carriers to offer plans that patients, as consumers of health care, can actually use. Through market forces, let patients, not bureaucrats or special interest groups, tell insurance carriers what coverage is desirable to include in insurance policies.

Rather than forcing insurance companies to include special benefits, let patients use catastrophic/high-deductable plans coupled with health savings accounts for their health insurance needs. Let Medicaid patients shop in the private market for their own low-cost health insurance, on an equal basis as everyone else.

7. Aggressively eliminate waste, fraud, and abuse in the Medicaid program

Research shows that as much as 30 percent of government health care expenditures are lost through waste, fraud, and abuse.[7] This is unacceptable for a government program that costs taxpayers over $500 billion a year.

The state office that manages Medicaid eligibility and enrollment must critically review qualifications and continually assess eligibility in a timely fashion. The state of Illinois tightened its eligibility review while making a concerted effort to eliminate waste fraud and abuse in its Medicaid program. The governor's office estimates a savings of at least $50 million dollars in FY2016.[8] If private insurers administer the state Medicaid program, they must be responsive to timely audits and oversight.

8. Resurrect the private insurance market for long-term care and encourage home-care

A large part of Medicaid expenses go toward long-term care insurance. A certain percent of seniors require institutionalized care, however, many patients would not only rather stay in their own homes but would lead more fulfilling lives in more familiar surroundings. Where practical, home-care should be utilized.

Legislation that tightens the eligibility requirements for Medicaid long-term care would encourage and enlarge the private long-term care insurance market.

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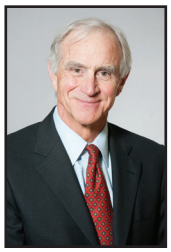
6 "Health insurance mandates in the states 2009," by V. Bunce and J. Wieske, Council for Affordable Health Insurance, 2009, at https://www2.cbia.com/ieb/ag/CostOfCare/RisingCosts/CAHI_HealthInsuranceMandates2009.pdf

7 "Shutting down fraud, waste, and abuse," by P. Viechnicki, et. al., Deloitte University Press, May 11, 2016, at https://dupress.deloitte.com/dup-us-en/industry/public-sector/fraud-waste-and-abuse-in-entitlement-programs-benefits-fraud.html

8 "Governor Rauner announces recommendations from health care fraud elimination task force report," Office of the Illinois Governor, October 19, 2016, at https://www.iml.org/file.cfm?key=10478



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Conclusion

We now have 50 years of experience with the Medicaid entitlement program. The new Republican bill to repeal and replace the ACA is a good starting point for meaningful Medicaid reform.

There is no question that Medicaid has helped millions of people, though it is not clear that it has served people better than private coverage would. There also is wide-spread agreement that it denies people access to many physician services because of low doctor reimbursement rates, and that it is not financially sustainable in its present form.

More government intervention can control costs, but only by rationing health care services people may receive. Countries with socialized medicine use patient waiting lists to ration health care, with the result that many people, especially the elderly, live with pain and stress while waiting for care.

This approach is not and should not be acceptable in the United States. Instead, policymakers at the state and federal level should increase choice, maintain or improve quality, and control costs to allow low-income patients to control their own health care dollars and make their own health care decisions. This patient-centered approach promotes respect and patient dignity, and is the only practical and moral way to make the Medicaid program financially viable over the long term.