

How Many Governors Does It Take To Reform Medicaid?

By John R. Graham

Medicaid versus Medicare

In July, President Bush appointed a Medicaid Advisory Commission to propose changes to the massive program. This is an important step to reforming a program truly out of control.

- Medicaid has a built-in perverse incentive that all but guarantees unaccountable spending growth by state politicians.
- Since 1970, Medicaid spending has grown two times faster than Medicare spending, as a share of national health expenditures.
- President George W. Bush's offer of waivers from Medicaid regulations to states that accept a cap on federal matching funds has the potential to limit spending growth and spark valuable innovation in state programs.
- President Bush and the Congress must hold the line against state politicians who simply want to seize more federal cash to bail out their Medicaid programs.

The perverse incentives of Medicaid

Fortunately, at least two Commission members will certainly propose reforms that will improve the ability of Medicaid to serve the interests of patients instead of the interests of governments: Robert Helms of the American Enterprise Institute, and Grace-Marie Turner of the Galen Institute.

Table 1 shows the importance of coming to grips with Medicaid. While Medicare's share of national health spending increased by 61 percent between 1970 and 2003, Medicaid's share increased by 121 percent. Medicare beneficiaries comprise an objectively defined group: people over the age of 65 who have paid into Social Security. Medicaid, on the other hand, is a type

of welfare program that gives states significant flexibility in defining which residents are eligible for coverage. Medicaid has moved to the front burner at both the state and federal level, with good reason.

The two programs now comprise almost exactly the same share of U.S. health spending. This disproportionate growth implies that the number of poor people has grown twice as fast as the number of elderly, which is unrealistic.

The law and regulations divide Medicaid coverage into "mandatory" and "optional." Because of this wooliness, an immediate result of the establishment of Medicaid was the widening of the eligibility net for state health benefits. From 1967 through 1972, state health spending increased by 36.6 percent *annually*. The increase in eligibility accounts for a full two thirds of this growth.¹ Coverage for optional services or populations is now the norm. Only 39 percent of Medicaid spending in 2001 was on mandatory coverage.² To understand why states launched a spending spree after Medicaid was established, one must understand how it is funded.

Table 1: Medicare, Medicaid Spending as Share of U.S. National Health Spending – Selected Years

	1970	1980	1990	2000	2003	Growth 1970-2003
Medicare	11%	15%	16%	17%	17%	61%
Medicaid	7%	11%	11%	16%	16%	121%
Federal Share of Medicaid	54%	56%	58%	58%	57%	

Sources: CMS 2003; Smith, *et al*; 2005; Wachino, Schneider & Rousseau 2005; author's calculations.

When Medicaid was launched in 1962, its architects thought that the states should administer the program but that the federal government should pay half the costs.³ The U.S. Constitution contains no hint of any authority granted to any branch of the federal government to establish either welfare or health-care programs. However, the U.S. government had long provided funding to subsidize medical costs for those on public assistance.

The 1950 amendments to the Social Security Act specifically authorized matching grants to states for direct payments to health-care providers that treated those on public assistance, and the 1960 Kerr-Mills Act expanded the pool of beneficiaries by including the “medically needy” who were not necessarily on public assistance.⁴ The subsequent introduction of Medicaid established a very simple formula for transfers from the federal government to the states. The federal government pays at least 50 percent of a state’s Medicaid costs, an extraordinarily perverse incentive.

The average citizen’s economic freedom is equally reduced, regardless of which level of government takes his or her money. It’s not immediately obvious that it matters whether the split is 50/50 or 25/75. However, the politician thinks differently. For the governor or state legislator, the taxes that the state raises are “his” and the taxes that go to the federal government are not. If he can get them for “free” it makes his political life a lot easier, and that’s what Medicaid offers.

For one dollar of “his” money, he can buy at least two dollars worth of political achievement. Nor does the federal government differentiate between “mandatory” and “optional” coverage: federal transfers cover both equally.⁵ Even worse, states with lower per-capita incomes actually get more than the standard hand-out. The federal share can go up to 83 percent.⁶ The Medicaid formula actually rewards states for poor economic performance.

Since 1970, the federal share of Medicaid spending throughout the U.S. has been quite stable, fluctuating between 54 percent and 60 percent.⁷ For the President and Congress this is a serious problem. There are no appropriations for the Medicaid budget. The money is simply “pulled” down by the states via a formula similar to that established 40 years ago, although eligibility has greatly increased since then.

In a very real sense, Congress does not control federal transfers to Medicaid; these were determined by

previous congressional sessions going back to 1965. It should, therefore, come as no surprise that state politicians are unwilling to tackle this “root cause” of Medicaid’s disproportionate expansion. For them, it serves as a health-care gravy train.

Medicaid reform was a highlight of this July’s meeting of the National Governors Association (NGA) in Des Moines, Iowa.

The quest for Medicaid reform

In May, in preparation for their annual meeting, the governors put together a reform proposal that they ratified at the meeting. The proposal does have some good ideas, including: cost-sharing through increased use of deductibles and co-payments; tax credits for low-income families to buy health insurance; and disqualifying people who make themselves eligible for Medicaid by transferring assets to relatives.⁸ However, while some of the proposals move in the right direction, the states’ perpetual begging in Washington threatens to hinder meaningful Medicaid reform. Any changes that do not address the funding formula fail to correct the perverse incentive facing state politicians.

States are now agitated over the so-called “dual eligibles.” These are Americans who get benefits from both Medicaid and Medicare. With the introduction of the Medicare Part D prescription drug benefit in 2006, many seniors whose prescription costs are currently subsidized by Medicaid will transfer those costs to Medicare. Because Medicare is taking over the costs, the federal government is naturally demanding a return of some of the transfer funding.

The Congressional Budget Office (CBO) estimates that this “clawback” will pull in \$124 billion from 2006 through 2015.⁹ States are complaining about the clawback, which they think is coming out of their coffers. However, at 57 percent of Medicaid’s bill of \$206 billion in 2003, the federal government kicked in about \$152 billion for that single year. A clawback of about four fifths of that amount, spread over a decade, amounts to a tiny reduction of the net transfer.

According to the NGA, “state budgets cannot sustain the costs associated with dual eligibles.”¹⁰ This implies that the federal government has some magical source of revenue, other than embattled taxpayers, that is unavailable to states. Some state politicians hold interesting notions about this magic source of cash.

New Hampshire state senator Robert E. Clegg Jr. (R-14th District) is under the impression that: “the federal government can print its own money.”¹¹ Actually, it can’t. It is against the law for the federal government to print money. The independent Federal Reserve System creates money through operations in the credit market, as it has done for almost a century. This central bank was established specifically to prevent government meddling in the money supply. While the states cry poverty, they fail to save money by getting a grip on Medicaid fraud, and come perilously close to engaging in it themselves.

The *New York Times* recently reported on its year-long investigation into New York Medicaid fraud. No less an expert than James Mehmet, former chief state investigator for the state’s Medicaid program, figures that 40 percent of claims are “questionable.” Of 40 million claims in New York in 2004, only 37 cases of fraud were uncovered by investigators.¹² Even worse, while ineffective at battling Medicaid fraud at home, states employ questionable practices to increase their federal transfers.

No fewer than 34 states have used contingency-fee consultants to design their programs to increase federal matching grants, despite the fact that federal policy forbids it in most cases.¹³ Although the states are generally unwilling to take more responsibility, President Bush has given them opportunities to do so. The Secretary of Health and Human Services has more latitude in signing waivers, sought by the states, from the federal requirements to which state Medicaid programs must adhere in order to get the money. However, as a trade-off for some of these waivers, states have agreed to accept funding caps on transfers from the federal government.¹⁴

This is similar to President Reagan’s policy during the 1980s.¹⁵ This year, the President has proposed legislation to give states more flexibility on program offerings, even without waivers. Americans, meanwhile, should not be concerned about a reduction in federal transfers to Medicaid. There is no law of nature stating that the federal government must subsidize the states by at least half. Consider, for example, the Canadian health-care system.

A lesson from Canada

Lengthy lines for diagnostic and surgical services typify government monopoly health care in Canada.¹⁶ Nevertheless, the financing is instructive. The Canadian system started out similar to the U.S. model; each dollar spent by provinces on hospitals and physicians automatically “pulled” one dollar from the federal government.

However, in 1977, this changed to block grants of cash and tax transfers. The provinces complain that this has reduced the federal share of funding, which is true.

Even the Canadian federal government, which has an interest in exaggerating the figure, claims that current transfers make up one quarter of health-care spending, and that they peaked at 41 percent in the 1960s.¹⁷ The independent Fraser Institute also estimates a federal transfer figure of one quarter for 2001-2002, but notes that the possible range lies between 22 percent and 40 percent.¹⁸ However, the miserable performance of the Canadian health-care system cannot be blamed on the reduction in federal funding.

Indeed, outside the United States, Canada spends more, per capita, on health care than any developed country except Iceland.¹⁹ Rather, the Canadian system’s failure is caused by government monopoly and lack of choice.

If Canada, which runs the least free health-care system in the developed world, can do it on half the share of federal funding than the U.S. does for its far less ambitious Medicaid program, Americans should not fear a significant reduction in the federal role. Policies that give states more responsibility for Medicaid will both encourage more fiscal discipline and improve services to patients.

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¹ Ginsburg 1984: 190, and references.

² KCMU 2005: 6.

³ Kleinke 2001: 4.

⁴ Ginsburg 1984: 181-182, and references.

⁵ Wachino, Schneider, and Rousseau 2004: 4.

⁶ For the formula, see Wachino, Schneider, and Rousseau 2004: 27.

⁷ CMS 2003.

⁸ NGA 2005a.

⁹ Pear 2005.

¹⁰ NGA 2005b.

¹¹ Pear 2005.

¹² Levy & Luo 2005a, 2005b.

¹³ GAO 2005.

¹⁴ Wachino, Schneider, and Rousseau 2004: 13.

¹⁵ Ginsburg 1984: 198.

¹⁶ Esmail & Walker 2004.

¹⁷ Finance Canada 2004.

¹⁸ Veldhuis & Clemens 2003. In Canada, it is not possible to calculate a precise figure within this range. Between 1977 and 2004, the federal government simply made one block grant to provinces to cover three areas: health, welfare, and education. Provinces did not disclose how they allocated the incoming transfers. Veldhuis & Clemens calculate a range for the federal share in 2001-2002 of 22 percent to 40 percent, with 25 percent being the most reasonable estimate.

¹⁹ Esmail, Walker, & Yeudall 2004.

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