

Taming the Medicaid Monster: The President Pushes Progress but States Shirk Solutions

By John R. Graham

Key Points

- Medicaid maintains a deeply rooted, perverse incentive that all but guarantees unaccountable spending growth by state politicians.
- President Bush continues to offer states more freedom to improve Medicaid via the Deficit Reduction Act and provisions in his 2007 budget.
- Most state politicians are not engaging this opportunity, preferring simply to complain about the federal government's demands for Medicaid accountability.
- Medicaid expansion reduces states' incentives to reform the private health insurance market and does not address issues usually attributed to the uninsured, such as emergency room (ER) overcrowding.
- President Bush's next best step for Medicaid reform is to develop a plan to convert all federal matching funds to block grants, over the protests of state politicians.

Nevertheless, events over the past 12 months have generally justified our disappointment. Most states are still addicted to Medicaid as a cash cow, from which they draw the milk of federal taxpayer kindness, without transforming this out-of-control program.

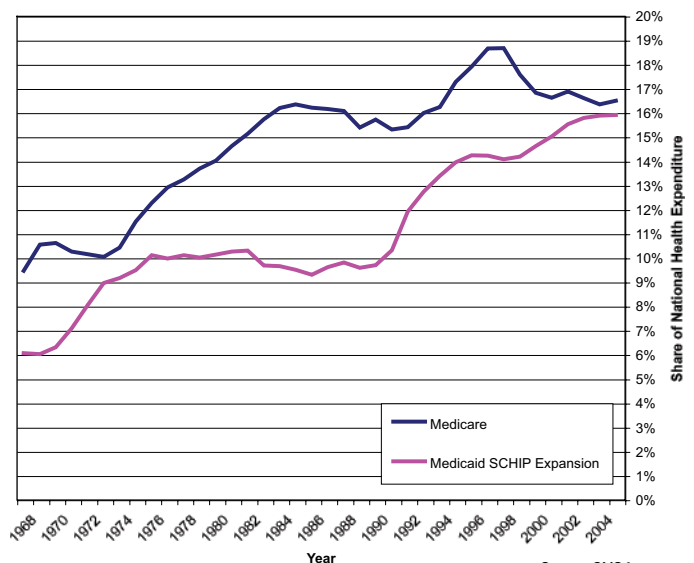
Table 1 shows how important it is to get a grip on Medicaid. While Medicare's share of national health spending increased by three quarters between 1967 and 2004, Medicaid's share increased by more than twice as much, such that the two programs now comprise almost exactly the same share of U.S. health spending. (SCHIP, the State Children's Health Insurance Program is included in these figures because that joint state-federal welfare program suffers from the same perverse incentives). For this disproportionate growth to be reasonable, the number of poor people in the U.S. would have had to grow twice as fast as the number of seniors, which defies reality. Much of Medicaid's poor fiscal performance has been in the last 15 years, a period in which Medicare's share of health spending has not trended upwards.

Medicaid Spending Is Out of Control

Last August, after a hiatus of almost two years, PRI re-launched the *Health Policy Prescriptions* series by asking the rhetorical question: "How Many Governors Does It Take to Reform Medicaid?" and noting that state governments were unwilling to make serious changes. We argued that the Medicaid funding formula gives them a perverse incentive to over-expand Medicaid, and congratulated President Bush for attempting to break this cycle of dependency.¹ Since then, the federal government has increased states' freedom of movement in this area.

Some states are creating "consumer-directed Medicaid," which will benefit both Medicaid beneficiaries and taxpayers. Leaders in this effort include governors Mark Sanford of South Carolina and Jeb Bush of Florida.²

Figure 1. Government Programs' Share of National Health Expenditure 1967-2004



Indeed, Medicaid is so out of control that its growth has dramatically outpaced both Medicare and private health spending, and still appears to be ramping up. In 2004, Medicaid, SCHIP, and expansion programs cost \$994 for every American (not every Medicaid beneficiary, for which the number is obviously much greater). While this looks tame compared to \$3,446 for private health spending, the gap has closed dramatically since 1967, when Medicaid spending was only \$15 for every American and private health spending \$120. In order to strip out the effect of inflation, as well as demonstrate the program's disproportionate growth relative to other health spending since 1967, Figure 2 shows real (i.e. inflation adjusted) spending on Medicaid (including SCHIP and expansion), Medicare, and private health care, per capita, indexed to 1967.

Figure 2. Index of Constant \$ Expenditure/Capita, 1967=100

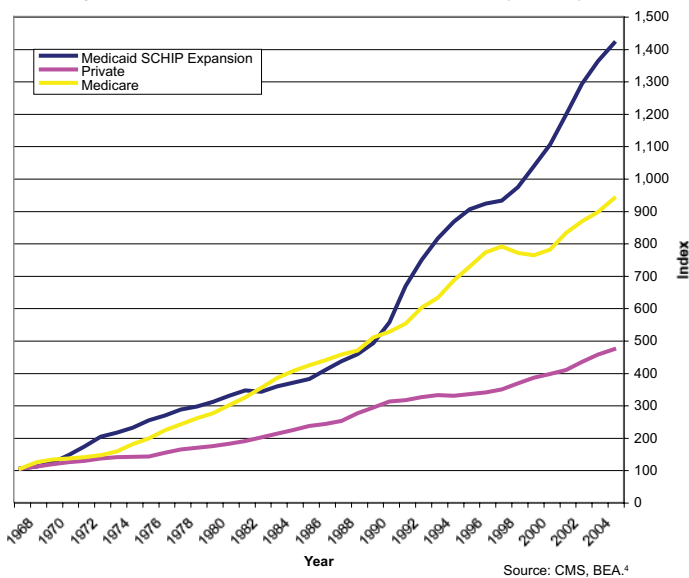


Figure 2 has immediate and dramatic impact. While every American spent almost five times as much (inflation-adjusted) dollars on private health care in 2004 as in 1967, he contributed more than 14 times as much towards Medicaid as he did before. The amount spent on Medicare went up by less than a factor of 10, which recalls the question of whether the number of poor people has grown dramatically faster than the number of seniors. Obviously, this is not the case.

Spending Is Out of Control For A Reason

Medicare basically covers people over the age of 65 who have paid into Social Security. Its beneficiaries comprise an objectively defined group. Medicaid, on the other hand, is a welfare program that gives states significant flexibility in defining which residents are eligible for coverage.⁵ The law and regulations divide Medicaid coverage into “mandatory” and “optional.”

Because of this wooliness, an immediate result of the establishment of Medicaid was widening of the eligibility net for state health benefits. From 1967 through 1972, state health spending increased by 36.6 percent *annually* and two thirds of the growth was due to increasing the number of eligible beneficiaries.⁶ Coverage for optional services or populations is now the norm: only 39 percent of Medicaid spending in 2001 was on mandatory coverage.⁷

Indeed, although Medicaid spending increased by 7.6 percent in 2004, and 6.9 percent in 2003, its spending growth per capita was less than that of private health insurance, at only 3.8 percent for 2003-2004. The rapid increase in spending was caused by more beneficiaries, rather than higher spending per beneficiary.⁸ To understand why states continue to enroll more and more people in Medicaid, we have to understand how it is funded.

The federal government pays at least 50 percent of a state's Medicaid costs. This creates an extraordinarily perverse incentive. For the citizen, his economic freedom is equally reduced whatever level of government takes his 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 of political achievement. Nor does the federal government differentiate between “mandatory” and “optional” coverage: transfer payments cover both equally.⁹

The President Continues to Reform

Last August's issue of *Health Policy Prescriptions* noted that President Bush had created opportunities for states to improve their management of this program, and he has continued to do so. The Medicaid Commission, appointed by President Bush last year, delivered an interim report last September, and is mandated to deliver its final report this December. Alongside changing how Medicaid pays for prescription drugs, (which *Health Policy Prescriptions* addressed last month), the Commission addressed tightening up the rules on “asset transfers,” whereby relatively affluent seniors qualify for Medicaid long-term care through accounting and legal maneuvering.¹⁰ The President has already acted on some of these proposals.

Through the Deficit Reduction Act (DRA), signed this February, and his 2007 budget, the President has invested significant political capital in reforming Medicaid in the right direction. The Congressional Budget

Office estimates that the DRA will save \$4.7 billion from 2006 to 2010, and \$21.7 billion from 2011 to 2015.¹¹ Of the 39 sections of Medicaid that the DRA opens up to reforms, only four require regulation from the Secretary of Health & Human Services.¹² Until now, states wanting to improve Medicaid faced huge obstacles because the law required a mind-numbing regulatory journey to get a waiver from the federal Centers for Medicare & Medicaid Services (CMS) - even for changes at the county level.

The President's 2007 budget includes further regulatory improvements. According to the Administration's July 2006 forecast, the federal share of Medicaid spending will increase by 4.6 percent per year for 2006 and 2007, versus an annual average of 7.2 percent from 2002 through 2005, and that federal Medicaid spending would grow eight percent, or \$224 billion, less over the next 10 years than had been anticipated in the President's last budget proposal.¹³ States should be excited about exercising their new autonomy in Medicaid program design.

In the Pacific Research Institute's latest book, *What States Can Do to Reform Health Care: A Free-Market Primer*, Nina Owcharenko of the Heritage Foundation discusses the reform options most likely to get control of Medicaid spending and increase quality.¹⁴ Successful ones include:

1. *Premium assistance* to help beneficiaries pay for private coverage, instead of just dumping them into a government program.
2. *Managed care or defined contribution* benefits, which have already demonstrated savings.
3. *Flexible benefit packages or cost sharing*, including distinguishing between families at 100 percent of the Federal Poverty Line and those at 300 percent, for example.
4. *Home and community-based services*, whereby states can decide which institutionalized beneficiaries can be better served outside the walls
5. *Health Opportunity Accounts*, which are like Health Savings Accounts for Medicaid (but limited to ten states as a demonstration).¹⁵
6. *Long-term partnerships*, a "carrot" which allows individuals to buy a private long-term care policy, with those asset-value of the policy exempt from determining their Medicaid eligibility. Although slightly counterintuitive, this reduces Medicaid costs by increasing the number of long-term care policies purchased, and reduces seniors' incentive to juggle their assets in order to qualify for Medicaid.
7. *Asset transfer enforcement*, the corresponding "stick" that reduces affluent seniors' ability to "shield" their true wealth, e.g. homes, from asset testing for Medicaid eligibility.

Some reforms have already borne fruit. For example, "cash and counseling," which moves the Medicaid subsidy from the provider to the patient, has shown measurable success in a number of waiver demonstration projects in New Jersey, Arkansas, and Florida, and is being implemented in twelve additional states as of this spring.¹⁶ Despite these encouraging signs, most state politicians are not very interested in hearing about such reforms.

States Continue to Resist

Rather than using their new freedom to innovate in Medicaid design and delivery, states invest most of their energy to ensure that they continue to draw down federal matching funds without limits. Indeed, this seems to be their primary concern with the federal role in Medicaid: 34 states have used contingency-fee consultants to design their programs to increase federal matching grants, despite the fact that CMS policy forbids it in most cases.¹⁷

Of course, the governors, speaking through the National Governors Association (NGA), want as much flexibility through waivers as they can get, but reject the principle that this be accompanied by limitations on the federal government's fiscal exposure. In its Medicaid policy statement, the NGA condemns credible budget neutrality for waivers, arguing that a state should have 10 years to achieve it, rather than just the five years that the federal government currently demands.¹⁸

Many state politicians are simply unwilling to understand that all the money belongs to the taxpayers. Instead, they perpetuate the meaningless notion that there is "federal money" and "state money." New Hampshire State Senator Robert E. Clegg Jr. has perfected this confusion, claiming to believe, "the federal government can print its own money. We can't."¹⁹

This June, the governors complained that the President's reforms cause a "cost shift" to states.²⁰ The governors have at least one legitimate grievance but also a way to solve it. The President intends to forbid states from levying so-called "provider taxes" to fund their Medicaid programs. Surely, this is an undue federal intrusion into state tax policy. However, the President also has a legitimate problem: taxes that states levy from providers to spend on Medicaid automatically draw down more federal dollars. So perverse is the resulting incentive that it has resulted in perhaps the only example in American history of a taxed industry lobbying *against* tax relief for itself. Hospitals and nursing homes actually like to be taxed - because those taxes get recycled back to them with federal dollars added on!²¹ Obviously, the states could negotiate to keep their power to levy provider taxes, but accept a cap on federal matching payments in return.²²

How Much Medicaid Do We Need?

Medicaid is a welfare program, but its natural tendency to expand has led to serious “mission creep” as other government interventions have degraded the private health insurance market, a topic discussed in our recent book.²³ This is so deeply rooted that even Tommy Thompson, the former Secretary of Health & Human Services, regarded as the father of welfare reform for his valuable efforts in that regard when governor of Wisconsin, succumbs to it. In a recent paper sketching out possible reforms to Medicaid, Thompson argues that “Medicaid is not doing its share to address the problem of the uninsured”; and that “states must be encouraged to expand Medicaid coverage.”²⁴

Indeed, it is likely that “open-ended” Medicaid *reduces* pressure to deregulate and improve competition, quality, and prices in the private market. About 12 percent of adults and one quarter of children who are enrolled in Medicaid also have access to employer-sponsored health insurance. Although intuition indicates that tightening Medicaid eligibility would reduce the number of patients receiving appropriate primary care, and drive them into expensive ERs instead, the behavior of Medicaid beneficiaries muddies this picture. Medicaid beneficiaries in fair or poor health are more than one and a half times *more* likely to visit ERs than uninsured Americans in fair or poor health.

Medicaid beneficiaries with two or more chronic illnesses are more than four times *more* likely to visit ERs than their uninsured counterparts. Nor is this because the uninsured have higher incomes than Medicaid beneficiaries (and are therefore more likely to be able to pay for a physician’s consultation rather than visit the ER): Medicaid beneficiaries (aged 18 to 64) who are below the poverty line are *more* than one and a half times likely to visit the ER than poor, uninsured patients.²⁵

Also, the matching formula has not resulted in distributing federal Medicaid funds to poor Americans fairly, because by simply comparing a state’s per-capita income relative to the national average, it ignores the number of poor residents. As a result, New York, with less than eight percent of the nation’s poor, received 13 percent of the federal government’s Medicaid matching funds in 2004, whereas Texas, with more than 10 percent of the country’s poor received only six percent of the funds. Vermont, Alaska, and Maine received twice as much as they would if funds were allocated based on poverty, while Nevada received half as much.²⁶

Conclusion: The Federal Government Must Close the Checkbook

Although President Bush’s leadership on Medicaid reform is exemplary, it remains clear that most states do not enjoy the leadership required to undertake seriously the changes required to get a grip on Medicaid. The President needs to concentrate their minds by proposing a plan to convert federal Medicaid matching funds to simple, straightforward, non-negotiable block transfers.

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- ¹ John R. Graham, “How Many Governors Does It Take to Reform Medicaid?,” *Health Policy Prescriptions*, Vol. 3, No. 1, (August 2005).
- ² Nina Owcharenko, *Florida and South Carolina: Two Serious Efforts to Improve Medicaid*, WebMemo #920 (Washington, DC: The Heritage Foundation, November 18, 2005).
- ³ Centers for Medicare & Medicaid Services, *National Health Expenditures by type of service and source of funds, CY 1960-2004* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2006). Available at http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.
- ⁴ Centers for Medicare & Medicaid Services, *National Health Expenditures by type of service and source of funds, CY 1960-2004* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2006). Available at http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage; and Bureau of Economic Analysis, *National Income and Product Accounts Tables: Table 1.1.9 Implicit Price Deflators for Gross Domestic Product* (Washington, DC: Bureau of Economic Analysis, May 4, 2006). Available at <http://www.bea.gov/nea/dn/nipaweb/csv/NIPATable.csv> 8/7/06.
- ⁵ Kaiser Commission on *Medicaid and the Uninsured, Medicaid: An Overview of Spending in “Mandatory” Versus “Optional” Populations and Services*, Report #7331 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2005).
- ⁶ Paul B. Ginsburg, “Public Insurance Programs: Medicare and Medicaid,” in *Health Care in America: The Political Economy of Hospitals and Health Insurance*, H.E. Frech III ed. (San Francisco, CA: Pacific Research Institute, 1984).
- ⁷ Kaiser Commission on *Medicaid and the Uninsured, Medicaid: An Overview of Spending in “Mandatory” Versus “Optional” Populations and Services*, Report #7331 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2005).
- ⁸ John Holahan & Mindy Cohen, *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004*, Report #7499 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2006).
- ⁹ Victoria Wachino, Andy Schneider, & David Rousseau, *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*, Report #7000 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 24, 2004).
- ¹⁰ Medicaid Commission, *Report to the Honorable Secretary Michael O. Leavitt, Department of Health and Human Services and The United States Congress* (Washington, DC: Department of Health & Human Services, September 1, 2005).

- ¹¹ CBO, *Congressional Budget Office Cost Estimate: S. 1932, Deficit Reduction Act of 2005* (Washington, DC: Congressional Budget Office, January 27, 2006).
- ¹² Robin Rudowitz and Andy Schneider, *The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2006).
- ¹³ CMS, *Medicaid Spending Projections Down Again, Reflecting Effective Federal and State Steps to Slow Spending Growth*, Fact Sheet (Baltimore, MD: Centers for Medicare & Medicaid Services, July 11, 2006).
- ¹⁴ Nina Owcharenko, "Options and Opportunities for State Medicaid Reform," in *What States Can Do to Reform Health Care: A Free-Market Primer*, John R. Graham ed. (San Francisco, CA: Pacific Research Institute, 2006), pp. 5-19.
- ¹⁵ For a discussion of the benefits of Health Savings Accounts, see John R. Graham, "2006: The Year of the Health Savings Account," *Health Policy Prescriptions*, Vol. 4, No. 1 (January 2006).
- ¹⁶ Alliance for Health Reform, *Cash & Counseling Moves into the Mainstream* (Washington, DC: Alliance for Health Reform, April 2006).
- ¹⁷ GAO, *Medicaid Financing: States Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, DC: Government Accountability Office, June 2005).
- ¹⁸ NGA, *Short-Run Medicaid Reform* (Washington, DC: National Governors Association, August 29, 2005).
- ¹⁹ Robert Pear, "States Rejecting Demand to Pay for Medicare Cost," *New York Times* July 4, 2005, p. 9.
- ²⁰ Governor Mike Huckabee & Governor Janet Napolitano, letter to U.S. Secretary of Health & Human Services Michael O. Leavitt (Washington, DC: National Governors Association, June 27, 2006).
- ²¹ Robert Pear, "Planned Medicaid Cuts Cause Rift With States," *New York Times*, August 13, 2006, p. 18.
- ²² I do not advocate provider taxes as an appropriate way to fund Medicaid, but nor do I advocate restricting the states' rights to levy them.
- ²³ J.P. Wieske, "Health-Insurance Reform in the States: Two Steps Backward in Some States, One Step Forward in Others," in *What States Can Do to Reform Health Care: A Free-Market Primer*, John R. Graham, ed. (San Francisco, CA: Pacific Research Institute, 2006).
- ²⁴ Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform* (Washington, DC: Medicaid Makeover, August 4, 2006). Available at www.medicaidmakeover.org.
- ²⁵ Peter J. Cunningham, "Medicaid/SCHIP Cuts And Hospital Emergency Department Use," *Health Affairs*, Vol. 25, No. 1, pp. 237-247.
- ²⁶ Pamela Villareal, *Federal Medicaid Funding Reform*, Brief Analysis No. 566 (Dallas, TX: National Center for Policy Analysis, July 31, 2006).
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