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# Why Congress Wants to Force More Americans into Medicaid

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One particularly disturbing feature has emerged from the closed-door negotiations on health care legislation: a massive expansion of Medicaid, the nation's largest welfare program.

It is now clear that roughly half of the projected reduction in the uninsured will be due to putting more than 14 million individuals into Medicaid. Congressional liberals' passion for Medicaid expansion may be puzzling to those who view health care reform as a means to improve the quality of care and achieve superior medical outcomes. But it does find support among certain health policy analysts. For example, in a recent article for the *New England Journal of Medicine*, Professor Sara Rosenbaum of George Washington University, a highly respected and prominent health policy analyst, laid out her case as to why much of health care reform should be built on Medicaid.[1] Curiously, Rosenbaum's views of Medicaid and its enrollees reinforce well-entrenched mythology.

**The Low-Cost Myth.** Rosenbaum states that "despite its broader coverage for a population that is markedly less healthy than average, Medicaid costs less. According to the CBO's [Congressional Budget Office] estimates for the House bill, per capita federal costs in 2019 would be $5,926 for coverage through an exchange, as compared with $1,826 for coverage through a Medicaid expansion."

However, Medicaid costs are often understated because only the federal cost is cited, not the total cost, which includes the state share of Medicaid. Moreover, the Medicaid average cost is lower because most non-disabled adults on Medicaid do not stay on Medicaid for the entire year.

But this argument—that Medicaid is better because costs are lower despite serving a population that is "less healthy than average"—is irrelevant if the program is expanded. With a Medicaid expansion to a projected 150 percent of the federal poverty level, for example, there will be millions of young, healthy adults age 18–24 who would be on Medicaid but are clearly not "less healthy than average."

**Medicaid Payment.** Rosenbaum argues that Medicaid is cheaper than private insurance because it "generally pays providers less than commercial insurers do." But this under-reimbursement is not good for Medicaid recipients, who often cannot find doctors who accept it. Rosenbaum acknowledges this fact and calls for higher reimbursement rates.

But this of course undermines her argument that Medicaid is cheaper than private insurance. For if Medicaid pays providers as much as private insurers do, then it will have similar costs as well.

When California considered its own version of health care reform recently, Governor Arnold Schwarzenegger argued that low rates for Medi-Cal

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(California's Medicaid program) were unfairly shifting costs to the private sector.[2] The Medicaid cost-shift is something to be fixed, not exploited.

**Absence of Profit?** Rosenbaum argues that providers make no profit from the program. In fact, however, dozens of managed care companies, including many that are publicly traded, have substantial Medicaid business. "Public" hospitals and nursing homes, including those still owned by state and local governments, opposed Bush Administration efforts to limit Medicaid reimbursement to 100 percent of costs.

If an entity receives more than 100 percent of the cost of providing a service, what is that called if not profit? Likewise, are pharmacists dispensing Medicaid-purchased drugs for no more than their cost? Of course not.

**Lower Administrative Costs?** Rosenbaum does not provide data to support her proposition that Medicaid "has lower administrative overhead costs than do private insurers." However, in 2010, the administrative cost of Medicaid is projected to exceed $20 billion, an amount that exceeds the cash benefits provided by the Temporary Assistance to Needy Families program.

The House and Senate bills contain a provision to let California continue a family planning waiver in which waiver applicants bypass the normal Medi-Cal eligibility process. California justified this unique exemption because *processing an application is too expensive*. But even some liberal groups say that Medicaid's administrative costs are *too low.* The Texas Center for Budget and Policy Priorities, for instance, argues that there needs to be even greater investment in "broken" eligibility systems.[3]

The House and Senate bills contain provisions on the use of "presumptive eligibility," meaning that individuals seeking Medicaid coverage would be presumed eligible—and be able to receive coverage—while their applications are pending. The rationale for presumptive eligibility is that, under the normal course of business, the 45-day window that states have to determine an individual's Medicaid eligibility is too long.

The problem with presumptive eligibility, though, is that it often covers people who are not eligible for Medicaid, including illegal immigrants. Furthermore, presumptive eligibility trusts the applicant to submit a completed and satisfactory application, which often does not happen. But Medicaid pays for their treatment nonetheless.

The delay in determining eligibility should be fixed through investing in technology that could determine a person's eligibility in less than 45 minutes. Instead, Congress would take an approach that would open the system up to even more waste, fraud, and abuse and is not accepted in Medicare or any other government assistance program.

**Medicaid Enrollees.** Rosenbaum characterizes Medicaid enrollees as a "poor, isolated, and high-risk population." In fact, the majority of individuals on Medicaid are children who are not in poor health. West Virginia recently surveyed its non-disabled adults on Medicaid.[4] The majority believed they would be on Medicaid only temporarily. Over half of adults on the Basic Plan expected to be on Medicaid for less than two years, and 80 percent expected to be on Medicaid for less than five years.[5] Of those on the Basic Plan, less than 10 percent rated their health status as "poor," and even among those on the Enhanced Plan, only 21 percent rated their health status as "poor."[6]

If the congressional leadership is successful in expanding Medicaid, the new population that will

1. Sara Rosenbaum, "Medicaid and National Health Care Reform," *New England Journal of Medicine*, October 14, 2009, at *http://healthcarereform.nejm.org/?p=2072&query=home* (October 21, 2009).
2. See "Fixing Our Broken Health Care System," at *http://www.fixourhealthcare.ca.gov* (October 21, 2009).
3. Celia Hagert, "Fixing the Crisis in Our Eligibility System," Center for Public Policy Priorities, March 9, 2009, at *http://www.cppp.org/research.php?aid=828* (October 21, 2009).
4. Tami Gurley-Calvez *et al.*, *Mountain Health Choices Beneficiary Report*, West Virginia University, July 2009.
5. *Ibid.*, p. 17.
6. *Ibid.*, p. 37.

be swept into Medicaid coverage will include millions of young adults age 18–24 who no longer live at home but are in college, graduate school, or work only part-time or part of the year and thus have income below 150 percent of the federal poverty level ($16,245 for an individual).

**Cheaper, but Not Better.** Rosenbaum states, "Medicaid's original goal was to 'mainstream' the poor into the health care system. Although the program has had a profound effect on access to care, the health care system in many parts of the country remains segregated, with low-income communities heavily reliant on a health care safety net consisting of community health centers, public and children's hospitals and other hospitals that treat a disproportionate number of poor people, and local health agencies."[7]

Curiously, the Baucus bill cuts nearly $45 billion from Medicare and Medicaid payments to those safety net hospitals. This is, of course, precisely how government entitlement programs control costs: cut reimbursements to providers. But lower payments mean that fewer of these hospitals and clinics could stay in business, which undercuts the safety net that Rosenbaum seeks to protect.

**Making the Problem Bigger.** A serious effort to mainstream the poor into the health care system would include the creation of a voucher system or a system of premium support that would enable Medicaid beneficiaries to have access to private coverage, just like their fellow citizens.

In the meantime, there is sound evidence that Medicaid beneficiaries have relatively weak access to physicians. Compared to private coverage, Medicaid has comparatively poor outcomes for patients in cancer and cardiac care. The response from the congressional leadership is not to fix the current problems in Medicaid but rather to add another 14 million to the program. This approach will not solve Medicaid's problems but only exacerbate them.

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7. Rosenbaum, "Medicaid and National Health Care Reform."