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How States Can Survive the Medicaid Crisis

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Along with the exploding costs of public-sector benefit packages, managing Medicaid is the greatest challenge confronting the nation's governors and state legislative bodies. About 16 percent of the nation's population is currently enrolled in Medicaid, the joint federal–state program for certain categories of *mostly* poor individuals. State budgets are stressed from explosive Medicaid growth, which has more than quintupled over the past two decades.

Four months from now, the extra Medicaid money delivered to states from the federal stimulus disappears. The loss of federal money, along with increased enrollment as a result of the recession, exacerbates the state crisis. All 29 Republican governors signed a letter to Congress and the White House asking that the Medicaid maintenance-of-effort requirements for eligibility in the new health care law be repealed.[1] Besides calling for increased flexibility on eligibility, states should also maximize opportunities to better manage their programs, control costs, and put in place fundamental long-term reforms.

The Premium-Support Model. Most Medicaid enrollees are children, their mothers, and pregnant women. Currently, Medicaid offers beneficiaries a fairly comprehensive one-size-fits-all benefit package and pays providers who deliver services. Despite the massive increase in Medicaid spending, many physicians fail to participate in the program because of low payment rates and mountains of paperwork.

There is also evidence that Medicaid enrollees receive a lower quality of care. A recent study from the University of Virginia found that Medicaid patients have worse surgical outcomes than individuals *without* insurance, even controlling for numerous confounding factors.[2] All of these components contribute to Medicaid's being a program in crisis.

An alternative to the government-centric structure of Medicaid is a premium-support model, under which individuals take state vouchers to purchase private health plans, including employer-based coverage, that best suit their needs. Enrollees would benefit from increased choice and improved access to providers.

States would likely experience budgetary savings from this model, mainly from (1) efficiency improvements from covering under a single policy all members of a family who are currently covered separately by different combinations of public or private plans, (2) administrative savings achieved by significantly reducing the need for the state's Medicaid program to operate systems that directly reimburse providers and verify claims, and (3) a more appropriate use of medical care by beneficiaries driven in part by greater care management and continuity of coverage.

Until a premium-assistance model can be implemented, officials can still take a number of actions to reduce the pressure on Medicaid's finances:

- ***Increase enrollee cost-sharing.*** Overutilization of medical services is a serious budgetary concern

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at all levels of government. Cost-sharing would give program recipients some "skin in the game" and exert downward pressure on program spending. Cost-sharing should increase when program beneficiaries utilize expensive care settings, such as the emergency room, for non-emergency care needs.

- ***Sliding scale for premiums.*** Premiums for Medicaid should be based on a sliding scale so that households with greater amounts of income pay a greater portion of the premium. The availability of funds is limited, and the sliding scale would provide greater funds to those who need them more. At the same time, the sliding scale would reduce both the perverse incentives that discourage upward mobility and the crowd-out of employer-sponsored insurance for individuals at the top of the eligibility thresholds.
- ***Manage program eligibility.*** Within federal guidelines, states should limit program eligibility to what is affordable to taxpayers. Eligibility should include a strong income and asset test that is reviewed several times a year to ensure the temporary nature of the safety net program. States might also wish to tighten retroactive eligibility.

Reform Medicaid for the Disabled and Elderly. Roughly two-thirds of national Medicaid spending goes to the elderly and disabled populations, with about half of that amount spent on long-term care (LTC) services.[3] Currently, nursing home coverage is a mandatory benefit under Medicaid, but states need a waiver in order to provide Medicaid-funded services in the home and community. This creates a bias toward nursing home care, which is something that most individuals prefer to avoid.

The following basic program reforms would likely improve recipients' care and lower government spending:

- ***Reduce eligibility exemptions.*** Given the program's generous federal exemptions, qualifying for Medicaid LTC support is not difficult. Current federal law allows individuals to exclude most assets and still qualify for Medicaid.[4] Furthermore, a growing legal industry that assists individuals with significant assets in becoming *cash* poor and qualifying for Medicaid corrupts the basic legislative intent of the program and exacerbates states' budget problems.[5] There is evidence from several recent economics studies that Medicaid both crowds out the purchase of LTC insurance and

1. The maintenance-of-effort requirements in the health care law indicate that a state could lose all of its federal Medicaid support if it drops out of the program. Republican Governors Association, "GOP Governors Ask Feds to Ease Healthcare Mandates," January 7, 2011, at *http://www.rga.org/homepage/gop-governors-ask-feds-to-ease-healthcare-mandates* (February 23, 2011).
2. Damien J. LaPar *et al.*, "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, No. 3 (September 2010), pp. 544–551.
3. See StateHealthFacts.org, "Distribution of Medicaid Spending by Service, FY2009," at *http://www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4,* and "Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007," *at http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4* (February 24, 2011).
4. The following are federal exemptions for Medicaid eligibility for LTC services: a home and all contiguous property with up to $500,000 in equity (or in some states $750,000), household goods regardless of value, one business including the capital and cash flow of unlimited value, and retirement funds such as individual retirement accounts up to $500,000. Other exemptions include one automobile of unlimited value, unlimited prepaid burial plans for the Medicaid recipient and immediate family members, and an unlimited amount of term life insurance.
5. The top two results and seven of the top 10 results when searching for "Medicaid" in the books section on Amazon.com are books promoting Medicaid planning techniques. The first book appearing as of January 21, 2011, is *How to Protect Your Family's Assets from Devastating Nursing Home Costs: Medicaid Secrets.* Here is a portion of the product description:

   > Written by an elder law attorney with over 25 years experience, this book will help anyone with a family member faced with a long-term stay in a nursing home who wishes to preserve at least some of their assets by qualifying for the Medicaid program. You don't have to be broke to qualify! … The book includes tips on: how to title your home so you do not lose it to the state; how to make transfers to family members that won't disqualify you from Medicaid; how annuities make assets "disappear"; smart tricks for "spending down" your assets; what to change in your will to save thousands of dollars if your spouse ever needs nursing home care; avoiding the state's reimbursement claim following the nursing home resident's death.

reduces saving rates.[6] Reducing eligibility loopholes would better conserve public resources for those who truly need assistance.

- ***Move away from the nursing home model.*** The nursing home bias exists even though average nursing home costs far exceed costs for services provided in the home or community and individuals prefer to avoid nursing homes. Many states have attempted to "rebalance" Medicaid LTC services through de-institutionalization, but states that have rebalanced more aggressively have had relatively large increases in Medicaid LTC spending. This suggests that controlling eligibility for Medicaid is a necessary first step in order to feasibly rebalance. Individuals who meet new state income and asset requirements should receive a fixed cash amount in order to choose both the type of care they receive and the most appropriate setting for that care. This should be coupled with incentives to limit spending.
- ***Improve care coordination.*** Care coordination for recipients of LTC services is often lacking. Less than 10 percent of spending for dual-eligible individuals (those with both Medicare and Medicaid) is covered under coordinated care arrangements. The Lewin Group has estimated that states could save around 8 percent of current expenditures by transitioning enrollees with disabilities into managed care.[7]

Stabilize Financing for Long-Term Solvency. The open-ended federal reimbursement of a substantial amount of state Medicaid spending creates incentives for states to spend carelessly. Each state creates a Medicaid program that is larger than it would be if its own taxpayers had to pay the entire cost. Worse, each time state budget situations deteriorated in the past decade, states received extra federal money for Medicaid. This enabled states to avoid making responsible reforms and set the stage for the current state predicament by incentivizing states to expand their programs beyond sustainability.

Fundamental Medicaid financing reform would benefit both the federal government and the states by putting Medicaid on a fixed budget. First, it would provide budgetary certainty at both levels of government. Perhaps most important, it would discourage states from leveraging additional money through the federal Medicaid reimbursement and impose discipline on state programs, making future crises less likely. An added benefit is that states would be responsible for their own money, so they would likely increase Medicaid enforcement to ensure that taxpayer dollars go to individuals who genuinely deserve public assistance.[8]

A Consumer-Centric Model. It is possible for states to improve care for program recipients while simultaneously reducing Medicaid spending. Increased flexibility in the federal government's Medicaid rules and waiver system is necessary to fully implement meaningful reform. This would put states on a path where the current government- and provider-centric model of Medicaid is replaced by a consumer-centric model, using free-market principles to improve quality and lower prices.

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6. Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," *American Economic Review*, Vol. 98, No.3 (2008), pp. 1083–1102; Geena Kim, "Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment," 12th Annual Joint Conference of the Retirement Research Consortium, 2010.
7. UnitedHealth Center for Health Reform and Modernization, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid," April 2010, p. 26, at *http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf* (February 25, 2011).
8. Despite the ability to do estate recoveries, only about 0.8 percent of Medicaid's national nursing home expenditures is recovered.