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Solving the National Medicaid Crisis

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On April 15, the House of Representatives passed a budget that addresses the Medicaid crisis. Introduced by Budget Committee chairman Paul Ryan (R–WI), it repeals Obamacare and its costly Medicaid expansion and puts Medicaid on a more fiscally sustainable path. Ryan's Medicaid reform ends the open-ended federal reimbursement of state Medicaid spending and allows states greater flexibility to manage their programs without interference from the federal bureaucracy. In contrast, the White House fails to appreciate the Medicaid crisis and instead relies on Medicaid to cover upwards of 20 million more people beginning in 2014.

State Medicaid Spending Has Grown Faster Than Other Major Categories

State Spending per Capita

	1989 (in 2009 Dollars)	2009	Growth Rate
Total Spending	$3,218	$5,038	57%
Medicaid Spending	$364	$1,065	192%
Elementary and Secondary Education Spending	$754	$1,092	45%
Higher Education Spending	$385	$526	37%
Corrections Spending	$102	$170	66%
Transportation Spending	$324	$391	21%

Note: Categories shown constitute roughly 60 percent of state spending.

Source: Author's calculations based on the 1990 and 2009 state expenditure reports from The National Association of State Budget Officers and population estimates from the U.S. Census Bureau.

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Medicaid in Crisis. Unsustainable spending growth, enormous crowd-out of private coverage, perverse incentives that discourage work and financial planning, and cost control mechanisms like low provider payment rates that limit access for enrollees and contribute to a low quality of care have left Medicaid in crisis.

Unsustainable Medicaid Spending. Between 1990 and 2010, national Medicaid spending increased from $72 billion to over $400 billion.[1] Federal spending alone has increased from $40 billion in 1990 to an estimated $271 billion in 2010. At the state level, Medicaid spending has increased four times faster than elementary and secondary spending, five times faster than higher education spending, and nine times faster than transportation spending over the past two decades.

Low Provider Participation in Medicaid. Several states reimburse Medicaid providers at extremely low rates, some lower than one-third of commercial rates.[2] Medicaid also requires an enormous

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amount of paperwork with lag times for payment twice as long as those for Medicare or commercial insurance. Moreover, the denial rate for Medicaid claims is three times that of Medicare and commercial insurance.[3]

As a result, only about half of all physicians accept new Medicaid patients. Small physician practices are increasingly deciding not to see Medicaid enrollees, so enrollees are increasingly served by a subset of providers.[4] In Texas, less than one-third of that state's doctors participate in Medicaid,[5] and a widespread access problem in Louisiana is frustrating both physicians and enrollees.[6]

Evidence of Poor Quality of Care. Physicians treat Medicaid patients in ways that can negatively impact their health and use fewer guideline-recommended therapies on Medicaid recipients.[7] Medicaid recipients also tend to lack a regular place of care and thus receive a greater proportion of their care in the emergency room, which has been shown to have high rates of medical errors.[8] On a larger scale, Tennessee's massive Medicaid expansion in the mid-1990s more likely reduced population health than improved it.[9]

Enormous Medicaid Crowd-Out of Private Coverage. Since Medicaid is heavily subsidized, eligibility expansions encourage individuals to switch from private coverage to government coverage, passing private costs to taxpayers. Jonathan Gruber and Kosali Simon estimated Medicaid crowd-out at 60 percent for expansions between 1996 and 2002.[10] This means that for every 10 people gaining Medicaid coverage, six of them simply replaced private coverage. Crowd-out is more likely to occur as Medicaid eligibility expands.

Perverse Incentives. For acute care services, Medicaid is in large part conditional upon low income and lack of assets. The loss of a Medicaid benefit can therefore penalize households that work hard and earn income or save an amount beyond the eligibility cutoff.

The impact of Medicaid on behavior is more pronounced on the long-term care (LTC) side. Although there are technically income and asset requirements for Medicaid LTC eligibility, they are irrelevant for most people. Most states have "medically needy" income criteria, which means health expenses can be deducted from gross income before the income test is applied. Since LTC services are quite expen-

1. Centers for Medicare and Medicaid Services, *2010 Actuarial Report on the Financial Outlook for Medicaid*, December 21, 2010, at *https://www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf* (May 4, 2011).
2. Medicare rates are generally estimated to be about 70–80 percent of commercial payment rates. And Medicaid rates, which vary considerably by state, are generally smaller than Medicare rates. Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index, 2008," at *http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4* (April 25, 2011).
3. AthenaHealth, "PayerView 2010: Improving the Way Providers and Payers Work Together," May 2010, at *http://www.athenahealth.com/_doc/pdf/whitepapers/PayerView_Whitepaper_2010_Final.pdf* (September 29, 2010).
4. Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change, August 2006, at *http://hschange.org/CONTENT/866/* (April 7, 2011).
5. Associated Press, "Doctors Threaten to Pull Out of Medicaid," July 12, 2010, at *http://www.nbcdfw.com/news/health/Doctors-Threaten-to-Pull-Out-of-Texas-Medicaid-98202569.html* (September 28, 2010).
6. Robert Pear, "Cuts Leave Patients with Medicaid Cards, but No Specialist to See," *The New York Times*, April 1, 2011, at *http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html?ref=robertpear* (April 5, 2011).
7. See James E. Calvin *et al.*, "Insurance Coverage and Care of Patients with Non-ST-Segment Elevation Acute Coronary Syndromes," *Annals of Internal Medicine*, Vol. 145 (November 2006), pp. 739–48.
8. Lucian L. Leape *et al.*, "The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II," *New England Journal of Medicine, Vol.* 324, No. 6 (February 1991), pp. 377–84.
9. Brian Blase, "Obama's Proposed Medicaid Expansion: Lessons from TennCare," Heritage Foundation *WebMemo* No. 2821, March 3, 2010, at *http://www.heritage.org/research/reports/2010/03/obamas-proposed-medicaid-expansion-lessons-from-tenncare*.
10. Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," *Journal of Health Economics*, Vol. 27 (2008), pp. 201–17.

sive, an individual would have to have a very high income to fail this test.

With respect to the asset test, there are generous federal exemptions that result in most people being able to qualify for Medicaid without spending down. As a result—and as attested to by several recent economics studies—Medicaid both crowds out the purchase of LTC insurance and reduces savings.[11] Furthermore, a growing legal industry assists individuals in becoming *cash* poor and qualifying for Medicaid, corrupting the basic legislative intent of the program and exacerbating budget problems.[12]

Obamacare Worsens Medicaid. In 2014, states must enroll every individual who resides in a household below 138 percent of the federal poverty level into Medicaid. This expansion will massively expand the welfare state by up to 25 million able-bodied adults.[13] Nonpartisan analysts at both the Congressional Budget Office and the Centers for Medicare and Medicaid Services estimate that this will increase *annual* spending on the program by around $100 billion.[14] Moreover, only 10 percent of primary care physicians (PCPs) believe that new Medicaid enrollees in their area will find a suitable PCP after the expansion.[15] Adding millions more individuals to Medicaid will likely cause a further deterioration in the quality of care Medicaid enrollees receive.

A recent study estimates that Obamacare's Medicaid expansion will result in an 82 percent crowd-out rate for working adults.[16] The combination of crowd-out and "woodwork" effects—where currently eligible but not yet enrolled individuals join Medicaid—will impose a new burden on states.[17] However, states will have very little incentive to control the cost of the expansion population as the federal government will finance 100 percent of the costs of the expansion population for the first three years and at least 90 percent of the costs thereafter.

The Ryan Medicaid Budget Plan. Currently, the federal government provides an open-ended reimbursement of at least 50 percent of every state's Medicaid spending.[18] The Ryan plan replaces the open-ended federal reimbursement with a fixed allotment to each state. Combined with additional flexibility, this provision would encourage states to form more cost-effective programs.

- ***It reins in inefficient state expansions.*** The open-ended reimbursement encourages states to

11. 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.
12. Six of the top 10 results when searching for "Medicaid" in the books section on Amazon.com are books promoting techniques for individuals to protect assets and qualify for Medicaid.
13. Richard Foster, "The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures," testimony before the Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011, at *http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Foster.pdf* (May 4, 2011).
14. Douglas W. Elmendorf, letter to Congresswoman Nancy Pelosi (D–CA), March 20, 2010, at *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf* (June 22, 2010); Richard Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, April 22, 2010, at *https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf* (June 30, 2010).
15. Doug Trapp, "New Medicaid Patients Will Lack Access, Most Doctors Say," Amednews.com, May 3, 2010, at *http://www.ama-assn.org/amednews/2010/05/03/gvsb0503.htm* (September 30, 2010).
16. Steven D. Pizer, Austin B. Frakt, and Lisa I. Iezzoni, "The Effect of Health Reform on Public and Private Insurance in the Long Run," March 9, 2011, at *http://ssrn.com/abstract=1782210* (May 5, 2011).
17. Although the federal government will pick up 100 percent of the cost for the first three years and at least 90 percent of the costs thereafter, it does not provide additional funding for the currently eligible but not enrolled.
18. The federal government reimburses state Medicaid spending at a percentage dubbed the Federal Medical Assistance Percentage (FMAP). The state FMAP is inversely related to state per capita income. Every state has an FMAP of at least 50 percent, although it can increase to nearly 80 percent in the poorest states.

overspend on Medicaid as most of a state's spending is paid by federal taxpayers. A fixed federal allotment would cause states to form more efficient Medicaid programs as states would have a greater incentive to ensure that taxpayer dollars go to individuals who genuinely deserve public assistance. The greater discipline imposed by the fixed allotments would therefore make future state budget crises less likely and decrease federal budget deficits. The CBO scored a similar version to the Ryan plan as saving about $680 billion between 2012 and 2020.[19]

- ***It provides budget certainty at the federal and state levels.*** A fixed budget would provide budgetary certainty for states and the federal government. Currently, the federal government has only a rough idea of its Medicaid liability. Having more transparency of Medicaid's costs would better inform policymakers of the trade-offs of their decisions at the federal and state levels.
- ***It encourages innovation to better serve the most vulnerable.*** Ryan's proposal allows states greater flexibility from federal mandates so they can better manage their programs. Allowing states to have the freedom to experiment is consistent with federalism, and it also enables states to be laboratories where they can adopt a variety of policies and learn from each other.

Reform, Not Expansion. Washington can no longer afford to kick the can down the road on serious Medicaid reform. Its unsustainable spending, inferior access to quality care, massive crowd-out of private coverage, and perverse incentives that discourage work and financial planning all underscore the need for fundamental Medicaid reform. Obamacare's massive expansion of Medicaid is simply not feasible given that the nation cannot afford the current program. Congressman Ryan's Medicaid budget proposal, on the other hand, is an important step toward improving the program for enrollees and taxpayers.

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19. CBO scored the Ryan-Rivlin block grant proposal to save $180 billion from Medicaid, with the repeal of Obamacare to save another $500 billion. Douglas W. Elmendorf, letter to Congressman Paul Ryan (R–WI), November 17, 2010, at *http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf* (April 11, 2011).

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2. Medicare rates are generally estimated to be about 70–80 percent of commercial payment rates. And Medicaid rates, which vary considerably by state, are generally smaller than Medicare rates. Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index, 2008," at *http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4* (April 25, 2011).
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