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Overloaded and Sinking - How to make Medicaid even worse, the Obama way

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In June 2005, after months of fierce debate over Social Security reform, the chairman of the National Governors Association (NGA) issued a sobering prediction. "Long before Social Security goes bankrupt," said Virginia Democrat Mark Warner, "Medicaid is going to bankrupt all the states." An exaggeration, perhaps, but the health-care legislation being mulled on Capitol Hill would make Warner's prediction more realistic.

According to the Congressional Budget Office (CBO), the bill passed by the House on November 7 would boost state Medicaid spending by a net total of $34 billion between 2010 and 2019. It would raise the Medicaid-eligibility threshold to 150 percent of the federal poverty line; force states to preserve their existing levels of Medicaid coverage through 2019 and also maintain current coverage levels among certain children enrolled in the Children's Health Insurance Program (CHIP); and require states to move some children from CHIP to Medicaid.

To help pay for this, the federal government would absorb, on average, 91 percent of the cost of insuring new state Medicaid enrollees who qualified for coverage under the 150 percent rule. By comparison, the average federal contribution to state Medicaid programs is typically around 57 percent. The feds pick up a bigger portion of the tab for CHIP (70 percent, on average), and the Pelosi bill would continue to reimburse states at CHIP rates for those children transferred from CHIP to Medicaid. By 2019, the CBO reports, the number of Medicaid beneficiaries would be 15 million greater than the combined number of Medicaid and CHIP recipients would be absent the legislation.

If that sounds mind-bendingly complicated, it is. But the upshot is that Pelosicare would significantly increase the burden on already unsustainable state Medicaid budgets. While federal subsidies would temporarily ease the blow, the net growth in state Medicaid expenditures from 2010 to 2019 would be enormous.

Pelosicare will have to be reconciled with whatever legislation the Senate produces. The bill designed by Senate Finance Committee chairman Max Baucus would lift the Medicaid-eligibility ceiling to 133 percent of the federal poverty line. The CBO reckons that Baucuscare would increase state Medicaid spending by $33 billion between 2010 and 2019.

According to a Heritage Foundation analysis, instituting the 133 percent threshold would enlarge individual state Medicaid populations by an average of 36.6 percent from June 2008 levels. The estimated jump would be 82.1 percent in Nevada, 80.7 percent in Montana, 76.9 percent in Texas, 70 percent in Colorado, 61.7 percent in Oregon, and 54 percent in Florida. California and New Jersey, two of the most fiscally ravaged states in America, would see their Medicaid populations swell by 34.2 percent and 47.1 percent respectively.

While the Medicaid issue has consumed far less political oxygen than Medicare cuts, tax hikes, and the "public option" have, it has caused heartburn among state governors, including Democrats. Tennessee's Phil Bredesen, for example, has complained that exacerbating state budget deficits "does not seem a very appropriate way" to extend health-insurance coverage. California's Arnold Schwarzenegger has protested that his state "cannot afford its current Medicaid program as structured and governed by federal rules."

In the Senate, meanwhile, several liberal Democrats are concerned that the proposed legislation would effectively penalize their home states for having already expanded Medicaid. In an October 22 letter to Baucus, Senate majority leader Harry Reid, and Senate Health Committee chairman Chris Dodd, 14 Democrats expressed frustration that tax dollars paid by their constituents would "go to states around the country that have consistently ignored the health care needs of their low-income residents without any acknowledgement of our original investment. That is unacceptable."

Amid this wrangling, it is worth reviewing Medicaid's original purpose and taking stock of its core deficiencies. Established in 1965 as a centerpiece of LBJ's Great Society, Medicaid was intended to provide health benefits for the needy. Over time, it has ballooned in size and cost, covering a growing segment of lower-income Americans. In fiscal year 2008, there were 62 million people (roughly one-fifth of the U.S. population) enrolled in Medicaid. According to the CBO, around half of them were poor children, and another quarter "were either the parents of those children or poor pregnant women."

The federal medical assistance percentage (FMAP) refers to the portion of state Medicaid costs paid by Washington; it varies from state to state based on income levels. The average FMAP is usually 57 percent, meaning that the average state is responsible for funding 43 percent of its own Medicaid program. However, as the CBO notes, the average federal share of Medicaid will hover around 67 percent through the beginning of fiscal year 2011, thanks to the economic-stimulus plan enacted last February. In fiscal year 2009, according to the Kaiser Commission on Medicaid and the Uninsured (KCMU), the FMAP for New Hampshire was just over 56 percent, while the FMAP for Mississippi was nearly 84 percent.

KCMU calculations show that the growth rate of total Medicaid spending in fiscal year 2009 was 7.9 percent, "a higher rate than the original projections and the highest rate of growth in six years." One would expect Medicaid rolls to mushroom during a nasty recession; the KCMU estimates that a spike of one percentage point in the unemployment rate yields a million new enrollees in Medicaid and CHIP. But the long-term explosion in state Medicaid spending has been driven primarily by the program's deep structural flaws.

For starters, the FMAP formula creates an unhealthy incentive for states to jack up their Medicaid expenditures. "It's perfectly designed to maximize fiscal irresponsibility," says Jim Frogue, vice president of the Center for Health Transformation (Newt Gingrich's health-policy think tank). If a state has an FMAP of 60 percent, every $1 it spends on Medicaid is matched by $1.50 from the feds. This arrangement has promoted profligacy and weakened accountability. As Cato Institute health-care expert Michael Cannon puts it, "Medicaid is like crack for governors and state officials."

Conservatives and libertarians have long advocated turning the program into a block grant -- in other words, giving each state a fixed amount of federal Medicaid dollars accompanied by highly flexible spending guidelines. This would encourage states to curb fraud and inefficiencies. Cannon suggests that Medicaid block grants could be modeled on elements of the 1996 welfare-reform bill. On the down side, says Frogue, if block granting were based on present levels of Medicaid spending, wasteful states would be rewarded and prudent states punished.

So how should Washington decide the value of state Medicaid allocations? Under the current framework, a state's FMAP is determined by its per capita income. American Enterprise Institute scholar Robert Helms, who served on the 2005-06 Medicaid Commission, argues that federal Medicaid allotments should instead be determined by factors such as a state's poverty rate, its tax-raising capacity, and the size of its disabled and long-term-care populations. This type of modified formula could be used to calculate lump-sum block grants.

A 2005 NGA report contrasted the rigidity of Medicaid with the relative elasticity of CHIP. Most states offer a one-size-fits-all Medicaid benefits package, even though Medicaid recipients are a heterogeneous lot (young and old, healthy and sick). It would be far cheaper -- and far more efficacious -- to target Medicaid services to specific groups. The NGA report also recommended that Medicaid permit enhanced cost sharing. Under CHIP, it observed, "states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services." But under Medicaid, such cost-sharing mechanisms have been severely restricted.

The Deficit Reduction Act signed by Pres. George W. Bush in February 2006 helped mitigate these problems by affording states more latitude to revamp their Medicaid programs. In response, Kentucky began offering four distinct Medicaid plans: "Global Choices" (for the general population), "Family Choices" (for children), "Optimum Choices" (for disabled adults), and "Comprehensive Choices" (for those requiring nursing-facility-level care). Idaho carved out three separate recipient categories -- low-income children and adults, the disabled and those with special needs, and elderly "dual eligibles" (who qualify for both Medicaid and Medicare) -- and established three corresponding benefit packages. West Virginia introduced a "basic" plan and an "enhanced" plan; to participate in the latter, recipients must sign a member agreement and fulfill various obligations.

In South Carolina, Gov. Mark Sanford pushed for a more radical overhaul: He wanted to implement Medicaid health-savings accounts (HSAs) that could be spent on private insurance. This proposal died well before Sanford's sex scandal erupted. It was even more ambitious than the Medicaid-privatization initiative Jeb Bush launched during his tenure as governor of Florida. The Bush program, now operating in certain pilot counties, essentially voucherizes Medicaid and lets beneficiaries purchase insurance from managed-care companies. Those beneficiaries can also decline Medicaid coverage and obtain a government subsidy to offset the cost of buying private insurance. A preliminary University of Florida study reckons that "Medicaid expenditures in Broward and Duval Counties were lower on a per member per month . . . basis during the first

two years post Reform than would have been the case in the absence of the demonstration project."

Given how many doctors refuse to accept Medicaid patients (owing to low physician-payment rates), the fundamental goal of Medicaid reform should be to assist the genuinely needy while encouraging those with sufficient resources to exit the program and acquire private insurance. In the short run, Medicaid HSAs and vouchers would certainly help enrollees -- but they could also have unintended consequences. As Cannon points out, they could increase Medicaid-participation rates, drive up costs, discourage recipients from leaving the program, and intensify their long-term dependence on government-sponsored health benefits.

On the other hand, until more states experiment with Medicaid HSAs and vouchers, we won't be able to evaluate their full impact. Unfortunately, Pelosicare would reduce states' ability to craft more flexible and innovative Medicaid policies. In its current form, the program is grossly inefficient and patently unsustainable. Its present trajectory will lead to fiscal ruin. As Governor Bredesen told the New York Times in July, "It's not health-care reform to dump more money into Medicaid." Too many Democrats are pretending otherwise.

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