National Center for Policy Analysis

BRIEF ANALYSIS
No. 192
For immediate release:
Friday, January 12, 1996

Making A Bad Program Worse

Clinton's Attempt at Medicaid Reform

Should Medicaid — the federal-state health insurance program for the poor — remain a federal entitlement or should the funds be turned over to state and local governments?

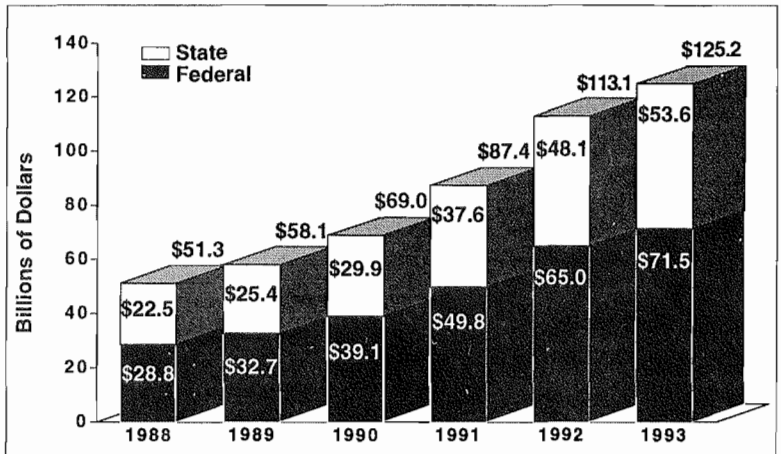
The Republican-led Congress wants to end Medicaid's entitlement status and block grant the federal government's contribution to the states with few strings attached. The majority of governors want the same.

Republicans hope to reduce the growth in federal Medicaid spending and allow states greater freedom to design more efficient health care systems for their low-income populations.

By contrast, President Clinton and many Democrats want to keep Medicaid's entitlement status and retain most of its mandates, restrictions and regulations. However, they would cap, or limit, the amount of money the federal government spends on the program to reduce the growth in federal Medicaid spending. Under their plan, Medicaid would operate much as it currently does, but with far less money.

Of the two approaches, the administration's plan is the worse, and the Republicans' is arguably the best approach possible, given the budget constraints.

Need for Change. Medicaid provides health insurance and nursing home services for about 36 million Americans, at an expected cost to the federal and state governments of about $157 billion in 1995. The cost has tripled since 1988. [See the figure.]



Note: Federal and state Medicaid expenditures, 1988 to 1993. Values are from the Urban Institute, based on data from the Health Care Financing Administration, and do not include expenditures in Arizona and the U.S. territories or adjustments, collections and administrative costs.

Source: John K. Iglehart, "Medicaid and Managed Care," *New England Journal of Medicine*, Vol. 332, No. 25, June 22, 1995, p. 1727.

One reason for the spending explosion is that Medicaid recipients bear virtually none of the cost of their health care and thus have no incentive to be prudent health care consumers. Another reason is that doctors and hospitals have weak incentives to deliver care efficiently. In addition, restrictions and regulations written in Washington make health care delivery more expensive than it needs to be.

As a result of these and other perverse incentives, fraud and abuse run rampant in the program. For example, an extensive 1993 investigative report of the Illinois Medicaid system by the *Chicago Tribune* found that:

- In one year, 71,064 Medicaid patients had more than 11 visits to a doctor's office (compared to a national average of six visits per year), while four patients had more than 300 visits in one year.
- In one day, one patient saw five doctors, made seven visits to a pharmacy and had 22 prescriptions filled with 663 pills.

Some providers are "Medicaid mills," freely prescribing drugs, syringes and other medical products — paid for with American tax dollars and sold on the street by those intent on abusing the Medicaid system.

President Clinton's plan would have little impact on these problems, and by imposing a cap on federal contributions to the program he would force the states to bear the full weight of any additional spending.

Clinton Plan: Costly New Burdens for State Governments. The administration's proposal to cap federal spending would lead to a number of problems:

Dallas Headquarters: 12655 N. Central Expy., Suite 720 • Dallas, TX 75243-1739 • 214-386-6272 • Fax: 214-386-0924 • E-Mail: ncpa@onramp.net
Washington Office: 727 15th St. N.W., 5th Floor • Washington DC 20005 • 202-628-6671 • Fax 202-628-6474

For more information: Jeanette Nordstrom or Curt Erickson 214/386-6272

- The caps would contribute to a huge unfunded mandate; states would be required to cover the same health care benefits they now cover, but the federal government's financial contribution would fall.
- As a result, state taxpayers would have to make up the difference through increased taxes.

The administration claims it intends to allow states more control over their Medicaid programs. However, the states would be limited in their efforts to make their programs more efficient because Washington would still make the policy. And the administration's program would require more bureaucrats — just to ensure that the cap was not breached.

In other words, President Clinton's plan to impose federal caps on Medicaid is just one more attempt to let Washington bureaucrats call the shots and make the states pay the bills.

Clinton Plan: Stifling Innovation. Ironically, while the administration complains that the states cannot be trusted to provide health care for their poor and disabled, it is the states that have been taking the lead in seeking solutions.

For example, 13 years ago Arizona received a Section 1115 waiver and created a comprehensive managed care program for its Medicaid population. An October 1995 report from the General Accounting Office notes that "While other states' per capita costs for Medicaid have continued to grow, Arizona's capitation rates declined by 11 percent in 1994." The report also states that "Arizona's program succeeded in containing costs by developing a competitive Medicaid health care market."

Indiana and Virginia legislatures have authorized pilot projects to provide their Medicaid populations with Medical Savings Accounts, while the Montana legislature gave the idea serious consideration in 1995 and is likely to pass a comprehensive Medicaid plan in its next session that includes MSAs.

In addition to providing health care for the Medicaid population, many of the states are attempting to extend their programs to low-income individuals and families that might not normally qualify for Medicaid.

By mid-1995, 10 states had received Section 1115 Health Care Financing Administration (HCFA) waivers, which permit them to enroll Medicaid patients in managed care plans. Eleven states had waivers pending, and eight other states had contacted federal officials about the possibility of obtaining waivers.

Of course, these programs are not perfect, and many people doubt that the managed care plans adopted by several states will be able to live up to their boast of providing comprehensive, quality care for less money — and there is plenty of evidence to justify those doubts.

But the point is that the states, not federal bureaucrats, are vigorously pursuing solutions to the problems of health care for the poor and uninsured. Block granting Medicaid to the states, ending its entitlement status and removing its restrictions would encourage further innovation. Block grants might even make the states more willing to try such novel approaches as allowing the poor and uninsured to control some of their health care dollars through Medical Savings Accounts.

By contrast, retaining most of the current restrictions and imposing caps on federal Medicaid contributions would stifle most of the states' creativity and make a bad program even worse.

This Brief Analysis was prepared by NCPA Health Policy Director Merrill Matthews Jr., Ph.D.