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Reforming Medicaid: More Flexibility for the States

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Medicaid is the largest single expenditure state governments face today. The country as a whole spends more on Medicaid than it spends on primary and secondary education. We also spend more on Medicaid (for the poor) than we spend on Medicare (for the elderly). And at the rate the program is growing, it is on a course to consume the entire budgets of state governments in just a few decades.

Needed Medicaid Reforms

- Block-grant federal funds to the states.
- Contract with private providers.
- Subsidize premiums for private insurance.
- Establish Health Savings Accounts for self-managed chronic care.
- Provide incentives to purchase Long Term Care insurance.

The Bush administration's budget proposes to reduce projected spending by $10 billion over the next five years, and some members of Congress have proposed a commission to recommend additional reforms. The nation's governors are preparing their own proposal. They would be wise to ask for no-strings-attached block grants. Barring that, there are other reforms that are long overdue.

How Medicaid Works. Medicaid is a complex system of federal matching funds with special pots of money limited to specific uses. This often results in wasteful spending. Currently, states are required to cover certain populations such as the disabled and pregnant mothers. States can receive additional matching funds to cover other populations, such as children in families who earn too much to qualify for Medicaid. Although coverage for some services is mandated, others, including prescription drug coverage, are optional. Yet, about two-thirds of Medicaid spending is on optional populations and optional benefits.

Needed Reform: Block Grants. The biggest problem with Medicaid is that each 40 cents spent by the states is matched by 60 cents of federal money. Thus states are tempted to go for the matching funds even when they know the spending is wasteful.

The matching scheme is also a bad deal for federal taxpayers. The average cost per Medicaid beneficiary nationwide is about $7,500. But because New York offers almost all optional benefits to all optional enrollees, it spends almost double the national average. Mississippi, which has a less generous benefit package and confines coverage mostly to the "mandatory" poor, spends just about half the national average. The result is that New York receives about twice as much federal money per enrollee as Mississippi, where the need is much greater.

We need to end the practice of matching grants coupled with wasteful regulations. States should instead request block grants covering all Medicaid, State Children's Health Insurance Program and disproportionate share hospital funds. States should have complete discretion, provided they spend the funds on indigent care.

Needed Reform: Contracting with the Private Sector. Private health plans are a much more efficient way to provide care than traditional Medicaid. Yet federal payment schemes can discourage their use. For example, Texas has announced plans to place 2.8 million urban Medicaid recipients into managed care health plans at an estimated savings of $109 million over two years. However, the proposal is being opposed by public hospitals that stand to lose $75 million worth of federally-funded disproportionate share payments given to hospitals that provide indigent care.

Needed Reform: Enrollment in Private Insurance Plans. Medicaid is an alternative to private insurance, and when the public sector expands, the private sector contracts. After all, why pay for insurance when it is available for free?

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Studies show that for every extra $1 spent on Medicaid, spending on private insurance contracts by 50 cents to 75 cents. Although the taxpayer burden grows, little is achieved as a result. This appears to have happened in the 1990s. Despite a large expansion in Medicaid spending over the decade, the uninsured rate over the period went up not down. That process needs to be reversed. States need to use Medicaid funds to enroll beneficiaries in private insurance — both individually-owned and employer-provided. There are enormous potential savings if, for example, the state could pay the employee's portion of employer-provided insurance premiums, letting the employer pay the bulk of the costs. But current rules make this reform difficult, if not impossible.

Needed Reform: Health Savings Accounts. Studies show that patients with diabetes, asthma, heart disease and other chronic conditions can reduce costs and improve quality by managing their own care. But self-managed care will be fully successful only if patients also manage some of their own health care dollars.

At least 25 states are experimenting with Cash and Counsel programs that allow disabled patients to manage their own money. But bureaucratic rules work mostly in the opposite direction. For example, Medicaid regulations limit cost-sharing by patients to nominal amounts, and forbid it outright for selected populations. And states that have copayments are allowed to charge enrollees only $3 or less for prescription drugs.

Needed Reform: Control of Long Term Care Costs. Nearly half of Medicaid spending is for long term care. Nationally more than two-thirds of nursing home costs are paid for by Medicaid — about double the rate only a decade ago. One reason for the increase is legal loopholes that allow individuals to meet Medicaid's asset test by transferring assets to offspring prior to entering a nursing home. Many couples have disguised assets by divorcing, assigning joint property to the "well spouse" while the "ill spouse" receives none. An entire "elder law" industry has sprung up in recent years to assist the elderly in hiding assets so Medicaid will cover their long-term care costs.

States need to (1) refuse to accept sham asset transfers, (2) broaden the classes of assets the state can recapture to recover its costs after the death of a nursing home resident and (3) give seniors financial incentives to choose home care over residential care and residential managed care over nursing home care.

A pilot project in four states called the Partnerships for Long Term Care (PLTC) provides financial incentives to purchase long-term care insurance. The plan allows consumers to shelter their assets by purchasing a qualifying private insurance policy with a defined amount of coverage. When policy holders enter a nursing home they first rely on the insurance. When they have exhausted their insurance, special eligibility rules allow them to receive Medicaid benefits while retaining assets equal to the value of the policy. For instance, a long-term care policy with $120,000 in benefits allows an individual to shelter $120,000 in assets and still qualify for Medicaid long term care. Since the average nursing home stay is a little more than one year, very few of those who have purchased policies have had to apply for Medicaid benefits. An inflexible 1993 federal law effectively limited PLTC to the four states that already had pilot projects. Repeal of the law would allow other states to establish similar programs.

Conclusion. Giving states both more flexibility and responsibility will go a long way in slowing the growth of Medicaid. Block granting Medicaid funds would let states deliver care in efficient ways, such as moving enrollees to private-sector managed care plans, premium subsidies for individual policies and employer-based plans, and Health Savings Accounts for self-management of chronic diseases. Finally, states should enhance asset recovery to recoup the costs of long term care, and institute programs to encourage private coverage.

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