

## 18. Medicaid

**M**EDICAID, the joint federal–state public health care program for the poor, is long overdue for comprehensive reform. Faced with growing fiscal demands and an outdated structure, it is struggling to meet the needs of a very diverse and expanding group of individuals that includes children, adults, the elderly, and the disabled. Like other entitlement programs, Medicaid is unsustainable and faces a financial crisis. However, Medicaid reform cannot be addressed in isolation, but instead should be considered within the broader context of comprehensive health care reform. It is vital that Medicaid be refocused to serve those who are most in need and that lawmakers consider other policy initiatives to decrease dependence on the program.

by *Nina Owcharenko*

### Notes

### Recommendations

**1. Restructure Medicaid’s financing.** The current Medicaid program is based on a federal matching rate that creates misguided incentives for states to leverage more federal dollars. The result has been expansion of Medicaid beyond its original scope, in part because of well-intentioned state efforts to help lower-income individuals and families, as well as the growing number of uninsured. The program has spread itself too thin, jeopardizing the quality of care for its enrollees, especially those who are most in need.

The existing matching rate system should be revamped to allocate scarce federal and state resources more efficiently and effectively to those states and individuals most in need. Instead of funding based on a provider-centered system, funding should be tied directly to enrollees. A patient-centered funding system would create a direct correlation between individual health care needs and the federal–state contributions. Linking Medicaid funding directly to individuals would help to create greater transparency and allow the states to identify higher-cost cases and provide more individualized care based on health status, ensuring that enrollees receive funds that better reflect their overall health care needs. Attention should also be given to untangling the Disproportionate Share (DSH) funds, which provide money to states and hospitals for uncompensated care, from the Medicaid program.

**2. Give states greater flexibility to make adjustments in their Medicaid programs.** Today, in order to manage expanding rolls and exploding costs, states are forced to micromanage the program by employing various cost-containment measures, such as restricting access to prescription drugs and lowering reimbursements to physicians and other health care providers, that ration care to enrollees. Such techniques may enable states to meet their yearly budgets, but they also directly affect quality and access to care and do nothing to solve the long-term fiscal crisis.

Many states are taking advantage of existing waiver authority to make broader changes in their Medicaid programs, but the process is burdensome and complex. Based on the successful welfare reform model, states should be given greater flexibility in designing and administering their Medicaid programs in exchange for meeting certain federal outcome measures. Such measures could include increasing the choice of private coverage options for Medicaid enrollees, slowing the rate of growth, increasing individual participation in health maintenance, and improving health outcomes.

**3. Simplify the process for directing Medicaid dollars toward private health care coverage.** Instead of enrolling in Medicaid itself, enrollees should be allowed to elect private health care coverage and receive a subsidy from Medicaid. A premium assistance option would give enrollees a choice. Today, the decision as to whether or not to provide such assistance is left to the states. Medicaid beneficiaries should have the ability to secure a private plan of their choice in lieu of traditional Medicaid and receive a contribution from Medicaid on their behalf.

Premium assistance could also be used in conjunction with a federal health care tax credit. For example, a mother who is eligible for a tax credit and whose child is eligible for Medicaid might prefer to have her family in one health plan. Thus, combining the mother's tax credit with the child's Medicaid contribution could make private health care coverage an attractive option and would help to mainstream families off of welfare.

**4. Broaden and integrate successful consumer-directed models, such as Cash and Counseling, to other Medicaid-dependent populations.**

As part of President Bush's New Freedom Initiative, states are allowed to give a small subsection of the Medicaid disabled population the ability to manage their non-medical care services. These individuals are given a budget and counselor to help them assess their needs and allocate their funds accordingly. The approach has broadened care options and has resulted in high levels of satisfaction among participants.

The concept of engaging enrollees in managing their own choices, with appropriate oversight, instead of being subject to the dictates of the Medicaid bureaucracy could have wide applicability throughout the

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program. Medicaid should be amended to allow more opportunities for beneficiaries to manage their health care spending, especially those who will be dependent on Medicaid throughout their lives.

**5. Eliminate incentives for individuals to qualify inappropriately for long-term care services under Medicaid.** Today's system encourages middle-class individuals to use estate-planning techniques to shelter assets in order to qualify for long-term care services under Medicaid. Stricter eligibility standards, combined with incentives for long-term care services, would ensure that Medicaid is protected for those who need it most. Through the Deficit Reduction Act of 2005, Congress took some limited steps to accomplish this objective, but more needs to be done. Incentives to help individuals prepare and save for their long-term care expenses would provide an alternative for many middle-income individuals and reduce the future burdens on Medicaid.

As with retirement savings, individuals must be encouraged to save for their future health care and long-term care costs. Many do not realize that Medicare, the program for individuals 65 years old and above, does not provide for long-term care services. Thus, educating and providing incentives for individuals to prepare for the future is crucial.

## Facts and Figures

- Medicaid provides care to over 53 million low-income Americans, three-fourths of whom are children and adults and 25 percent of whom are elderly and disabled. However, over 69 percent of all Medicaid spending is allocated to the elderly and disabled.
- Total federal and state Medicaid expenditures will reach \$349 billion in 2007, of which 57 percent (\$199 billion) is federal and 43 percent (\$150 billion) is state.
- Medicaid accounts for 22 percent of all state spending—the largest expenditure in state budgets, exceeding education and other important state services.
- Medicaid has grown from 0.3 percent of GDP in 1970 to 1.5 percent in 2004 and, combined with Medicare, could reach as high as 12.6 percent by 2050.

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## Additional Reading

Nina Owcharenko, "Florida and South Carolina: Two Serious Efforts to Improve Medicaid," Heritage Foundation *WebMemo* No. 920, November 18, 2005, at [www.heritage.org/Research/HealthCare/wm920.cfm](http://www.heritage.org/Research/HealthCare/wm920.cfm).

Nina Owcharenko, "A Road Map for Medicaid Reform," Heritage Foundation *Backgrounder* No. 1863, June 21, 2005, at [www.heritage.org/Research/HealthCare/bg1863.cfm](http://www.heritage.org/Research/HealthCare/bg1863.cfm).