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Solving the Medicaid Puzzle

Ideas and Strategies for State Entitlement Reform

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EXECUTIVE SUMMARY

Medicaid, one of the costliest and fastest-growing of America's entitlement programs, is also the largest one that falls under the supervision of state governments. As Congress continues to debate entitlement reforms at the federal level, states should demand the authority to address the many problems that face the Medicaid problem. These include:

Problem #1: Cost

For the average state today, Medicaid expenditures are nearly as large a share of total state spending as K-12 education and surpasses spending for higher education, transportation, and corrections. Whether paid for by federal funds or state funds, this expansion in Medicaid has resulted in less money available for family needs or other government expenditures.

Problem #2: Mismatch of Means and Ends

Most Medicaid recipients are eligible for the program because they are enrolled in a cash welfare program. But since Medicaid is provided in the form of health insurance, rather than cash, recipients can benefit only by consuming health care. This “use it or lose it” feature inflates medical costs while preventing recipients from using public assistance to develop the occupational skills, literacy, savings, or assets they require to become self-sufficient.

Problem #3: Quality of Care

Because of low reimbursement rates and other problems, many physicians do not accept Medicaid patients. Nor do those patients have much of a “say” in the care they receive, because they aren't paying for it. Neither of these conditions promotes good quality care.

Problem #4: Personal Responsibility

Medicaid is the primary funder of long-term care for the elderly. One important reason why people don't plan ahead for predictable future medical needs such as nursing home care is that they know those needs, if serious enough, will be paid for by the government. This promise of free or subsidized long-term care not only discourages personal responsibility but leads to an immoral transfer of money from current taxpayers, many young and of extremely modest means, to older Medicaid recipients who are solidly middle-class in background and family assets.

Medicaid and Managed Care

Some states have attempted to solve Medicaid's problems by contracting out portions of the Medicaid population to managed care organizations. Their experiences can be summed up in three points: 1) Medicaid managed care affects mostly the non-disabled, non-elderly portion of the caseload and thus excludes most Medicaid spending; 2) managed care does appear to save program costs initially, but higher administrative costs eat up some of these savings; and 3) quality of services under Medicaid managed care has remained about the same overall, improving in some states but seeming to deteriorate in others.

Arizona's Medicaid system is often viewed as the most successful in using managed care to reduce cost. It awards contracts to competing health plans to provide medical services in particular regions or counties of the state. Arizona did see its Medicaid costs drop substantially after the competitive contracting system was established in the early 1980s. But its program costs for the non-disabled, non-elderly Medicaid population have since grown at about the same rate as would have occurred under fee-for-service medicine. Arizona is also one of the few states to use managed care contracts to deliver long-term care services, and has saved significant sums—but mostly by tightly controlling eligibility rather than by the contracting process itself.

A Four-Part Medicaid Reform Strategy

A key element of a successful Medicaid reform strategy will be recognizing that Medicaid is not a program but a set of programs, with different goals and different problems. Reformers will have to divide Medicaid into its four constituent parts, and then use the appropriate policy to address each part's unique needs. These parts include:

1. Poor Children and Adults

For this population of families on public assistance, states should continue to reform cash welfare programs (which serve as a gateway to Medicaid eligibility) while converting Medicaid dollars into vouchers for 1) the purchase of private health insurance, 2) enrollment in managed care either through a state purchasing pool or some other means, or 3) deposit in medical or other savings accounts. Like other forms of public assistance, these Medicaid vouchers should be subject to time limits, work requirements, and other rules.

2. The Near-Poor Uninsured

Many women and children whose incomes do not fall below the income thresholds required to receive cash welfare assistance are nevertheless eligible for Medicaid. A better way to promote access to health care services would be to reduce state mandates that raise the cost of health insurance and to treat any Medicaid subsidy for those above the poverty line as a loan rather than a grant.

3. The Disabled

States should continue the process, begun by Congress in its 1996 welfare legislation, to target programs for the disabled only to those whose medical conditions truly make them permanent "wards of the state." They should also experiment with competitive contracting and managed care to deliver services to these disabled recipients more efficiency and effectively.

4. The Elderly

States should more rigorously enforce asset-transfer, asset-recovery, and spousal-support requirements, while ending all disincentives for adults to plan for their future medical needs through medical savings or long-term care insurance. In the long run, states and the federal government should consider setting an age requirement for Medicaid coverage to further encourage personal planning and responsibility.

Part 1

Introduction

The issue of reforming government entitlements lends itself to demagoguery and inconsistency. One congressman, a powerful Democrat from California, exemplifies the political risks inherent in the entitlement debate. Back in 1991, as chairman of the House Budget Committee, this lawmaker called for deep cuts in the growth of the Medicare program as part of a long-range plan to eliminate the federal budget deficit. He said that massive programs that benefit the elderly and other groups cannot and should not be shielded from change. "We really want to provide some straight talk here," he continued. "We cannot just pretend that things can be passed off to the future."[1]

Under his plan, spending growth for Medicare, Medicaid, and other entitlement programs would have been slowed by $400 billion. He also endorsed reductions or changes in Social Security to alleviate the tax burden on younger workers. For all his power as head of the House Budget Committee, however, the lawmaker wasn't able to make much headway in entitlement reform. His fellow Democrats wouldn't go along while Republicans, lambasted for a propose $25 billion cut in Medicare growth the year before, weren't willing to stick their necks out again.[2]

The congressman, Leon Panetta, learned his political lesson. Five years later, as chief of staff to President Bill Clinton, he helped craft a political strategy to characterize Republican Medicare proposals as an "attack on the elderly," even though they would have reduced spending growth less than the plan he had crafted in Congress.

An economist familiar with so-called "games theory" analysis might view entitlement reform as a kind of "Prisoners' Dilemma." While it would clearly be in the interest of each side to end burgeoning entitlement growth, either to fund new discretionary programs (for Democrats) or cut the tax burden (for Republicans), the short-term political incentive is for one side to cry foul if the other steps forward with a proposal. This tends to doom any serious effort at reform.

The 1996 welfare reform bill passed with great fanfare in Congress would seem to disprove this thesis. But cash welfare benefits such as Aid to Families with Dependent Children (AFDC) have never enjoyed the popularity of other entitlement programs, partly because of their historical disconnection with the world of work and family in which most people reside. Social Security and medical assistance are in a different category. To reform them will require imagination, leadership, and public education.

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1 R. A. Zaldivar, "Democrat: Cut Medicare," *The Charlotte Observer*, December 13, 1991, p. 3A.

2 Ibid.

The political economy of entitlement reform isn't just a Washington phenomenon. States administer much of the federal welfare state, and share in the cost in many cases. Medicaid, the joint federal-state program of medical assistance to the disadvantaged, poses as much of a problem for state leaders as Medicare and Social Security do for their federal counterparts. Years of double-digit increases in state Medicaid spending have crowded out other traditional state responsibilities and put great pressure on state taxpayers. A model developed by Wharton Econometric Forecasting Associates (WEFA) and the Heritage Foundation found that states will need to raise taxes or reduce other spending by a cumulative $146 billion by the year 2002 in order to meet current Medicaid obligations.[3] Given the talk in some state capitals of further expanding Medicaid to encompass more children, this estimate should be viewed as a conservative projection of the future cost of the Medicaid entitlement to state taxpayers. Of course, these same taxpayers will have to foot the federal bill for Medicaid growth, which will be even larger.[4]

It is no exaggeration to say that unless state governments can control Medicaid costs, they will have to raise taxes significantly or reduce other state services. While there are some promising experiments underway to reduce costs for some services, no state has yet grappled with the difficult question of how broad government's promise of free medical and nursing home care should be. Answering this question may well mean imposing time limits on Medicaid, rethinking who will be eligible for the program, and fundamentally changing its structure and financing. Considering the experience of Panetta and other lawmakers, one might doubt the willingness of any state leader to take such risks. But the inevitable fiscal reckoning states face may leave them no choice.

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[3] William W. Beach, "Updated Estimates of the Costs to the States of Not Reforming Medicaid and the Additional Costs of Adopting Per-Capita Caps," *F.Y.I.*, no. 81, The Heritage Foundation, December 18, 1995, p. 1.

[4] Ibid.

Part 2

Overview of the Medicaid Program

Medicaid was the end result of a long debate about the role of the federal government in medical insurance. Beginning in 1915, various efforts to establish government health insurance programs have been introduced in Congress or pitched to presidents. The debate expanded significantly during World War II, when fringe benefits were increased for many private sector workers to compensate for the government's war-time limits on direct wage increases. Both Congress and President Harry Truman considered national health insurance proposals in the late 1940s, but none came to a vote.

Federal involvement in health care for the needy actually began in 1950. States had previously operated a smattering of programs providing either direct health services or reimbursements to doctors and hospitals for indigent care. In 1950, Congress authorized limited federal financial participation in state medical assistance programs. Debate continued about a health care "safety net" for the elderly, poor or not, resulting in the Kerr-Mills bill of 1960 creating some federal medical assistance for the non-poor aged.[5] For many congressional liberals, health care had become the means by which the post-New Deal federal government could expand its aid to the disadvantaged.

Finally, after five years of spirited debate, the Social Security Amendments of 1965 created two programs destined to become core components of the entitlement state. The first, and by far the more noteworthy at the time, was Title XVIII creating Medicare, a comprehensive health insurance program for senior citizens. Almost as an afterthought, Congress also enacted Title XIX of the amendments to create Medicaid to provide health care services to the poor. The latter was intended to supplant what were perceived as spotty and inadequate state programs for medical assistance.

During debate over the bill, proponents claimed that the new health care programs would cost the federal government very little. Hospital costs for Medicare, for example, were projected to reach $9 billion by 1990. (The actual cost of Medicare hospital insurance that year was $67 billion.)[6]

Medicaid was also supposed to stay a relatively low-cost program. In its first year, the program cost $1.3 billion—$600 million from federal coffers and $700 million from the states. By 1970, the federal government had begun to pay a majority of the bill and the total cost topped $5.3 billion.[7] Over the next 25 years, Medicaid expenditures grew exponentially, reaching $159.5 billion in the 1995 fiscal year. About $89

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5 "Brief Summaries of TITLE XVIII and TITLE IX of the Social Security Act," Web Page, Health Care Financing Administration Web Site, August 23, 1996.

6 Daniel J. Mitchell and Stuart M. Butler, "Health Care Debate Talking Points #2: Why the Numbers Will Be Wrong," F.Y.I #22, The Heritage Foundation, August 9, 1994, p. 8.

7 "Health Care Chartbook," *Issue Brief*, U.S. House Republican Conference, April 28, 1994, p. 7.

billion of that price tag was paid by the federal government, with the remaining $70.5 billion coming from state (and some county) budgets.[8]

The table nearby summarizes Medicaid trends from FY 1987 to FY 1995. This has been a period of exceptionally rapid growth, due to various factors including federal and state expansions of eligibility, general medical inflation, and an economic recession that expanded welfare rolls.

Table 1: Medicaid Recipients and Expenditures, FY 1987–95 (In Billions of Current Dollars)

Fiscal Year	Recipients (Millions)	Total Spending	Federal Share of Total	State/Local Share
1987	23.1	50.1	28.0	22.1
1988	22.9	54.2	30.5	23.7
1989	23.5	60.9	34.4	26.5
1990	25.3	72.2	40.9	31.3
1991	28.3	94.4	52.4	42.0
1992	31.2	120.2	68.5	51.7
1993	33.4	130.7	76.1	54.6
1994	35.1	143.8	81.7	62.1
1995	36.3	159.5	89.0	70.5

Source: Health Care Financing Administration

A. Medicaid Eligibility

The number of Medicaid recipients, like expenditures, has grown tremendously since the inception of the program. In 1967, there were about 10 million Americans enrolled in Medicaid. By 1996, the number reached 37.5 million, an increase of 275 percent. Just from 1990 to 1996, the percentage of the total civilian population enrolled in Medicaid increased from 10 percent to nearly 14 percent.[9]

Beginning as a program intended primarily for recipients of federal welfare programs, Medicaid has become an amalgam of at least four distinguishable programs serving very different populations.

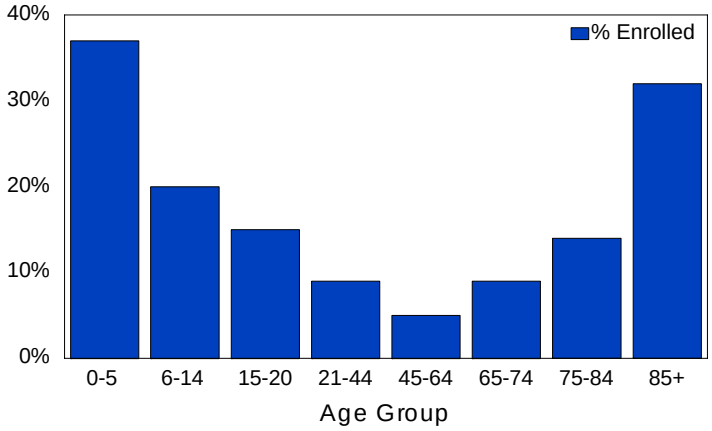
Neither the growth of the general population nor that of various subgroups can explain most of the increase in Medicaid recipients and expenditures. Instead, a major factor has been federal and state eligibility expansions. Beginning as a program intended primarily for recipients of federal welfare programs, Medicaid has become an amalgam of at least four distinguishable programs serving very different populations: 1) automatic health insurance for all welfare recipients below the poverty line, 2) medical care for pregnant women and young children of modest but not poverty-level income, 3) long-term medical and custodial care for Americans with serious medical conditions or disabilities, and 4) long-term medical and custodial care for elderly Americans.

8 "Medicaid Recipients, Vendor, Medical Assistance, and Administrative Payments," Medicaid Table 1, Data and Statistics Page, HCFA Web Site, updated October 18, 1996.

9 "1996 Statistics at a Glance."

Before examining each of these groups in some detail, it is important to recognize how the role of Medicaid in the lives of Americans differs by age (see Figure 1). The percentage of age-groups enrolled in Medicaid follows an inverted bell-shaped curve. About 37 percent of children up to five years of age, and another 20 percent of children between 6 and 14, are covered by Medicaid. In the middle of the age distribution—adults aged 45 to 64—only five percent are Medicaid recipients. By age 85 and over, the percentage goes back up to 32 percent. What this really means is that a substantial number of American families are receiving medical assistance from their state governments to which at least one member of the family is entitled by federal law. For most of these families, however, the recipient is either a young child or an elderly parent or grandparent.

Figure 1: 1995 Medicaid Coverage by Population Group



Source: Health Care Financing Administration

There are two main routes to Medicaid eligibility. The first, and most important in terms of enrollment, is being "categorically needy." This simply means that the recipient becomes eligible for Medicaid by first becoming eligible for other welfare programs such as Temporary Aid to Needy Families (TANF), formerly known as AFDC, and Supplemental Security Income (SSI). Federal laws requires all recipients of TANF (referred to from now on as AFDC to reduce confusion) to be made automatically eligible for Medicaid. For the aged, blind, or disabled, categorical eligibility can be based either on receiving SSI or on more restrictive state standards established before 1972—though in practice most states have expanded eligibility up to the SSI standard.

Other examples of "categorically needy" groups automatically eligible for Medicaid under federal law include:

- Recipients of adoption assistance and foster care.
- Medicare recipients whose income and status qualify them for Medicaid, which is used to pay the premiums and cost-sharing expenses for Medicare services.
- Infants born to Medicaid-eligible women, and children under age 6 and pregnant women whose family income is at or below 133 percent of poverty. Also, all children under age 19 living below the poverty line, regardless of whether they are on AFDC, will be eligible for Medicaid by the year 2002, under existing federal law.
- Recipients who are transitioning from welfare to work. Persons who lose AFDC or SSI payments due to earnings retain Medicaid coverage for a period of time (depending on the state and program).

In addition to those categorically needy for whom Medicaid is a federal entitlement, other groups can be added at a state's discretion. These include:

- Infants up to age one and pregnant women whose income is below 185 percent of poverty.
- Certain aged, blind, or disabled adults who don't qualify for SSI but have below-poverty incomes.
- Children under age 21 who meet AFDC income and resource standards but are not otherwise eligible for cash assistance.
- Individuals in mental or other institutions under certain income and asset limits.
- Person who would be institutionalized but are receiving care under home and community-based service waivers.[10]

The categorically needy make up the bulk of Medicaid caseloads and expenditures. However, the percentage has gone down in recent years because of legislation changing the definition or status of some recipient groups. Still, in 1995, 66 percent of all Medicaid beneficiaries were categorically needy and 62 percent of all Medicaid vendor payments were made on their behalf.[11]

The Medicaid needy option, combined with widely used techniques for shifting assets to children or others, makes Medicaid a true middle-class entitlement for millions of recipients.

In addition to these optional categories of eligibility, states can also elect to serve what are termed “medically needy.” These recipients have too much income to qualify for cash welfare benefits or Medicaid by category, but who face significant expenses for medical or custodial care. In effect, this option allows them to “spend down” to Medicaid eligibility by incurring medical and/or custodial care expenses to offset their excess income, reducing it to the maximum allowed by their state's Medicaid program. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the state representing the difference between family income and the income eligibility standard.[12]

The medically needy option, now in place in 40 states, is mainly used by families of disabled or elderly individuals to qualify for medical assistance regardless of previous economic status. Combined with widely used techniques for shifting assets to children or others, it makes Medicaid a true middle-class entitlement for millions of recipients.

B. Medicaid Services

Before discussing the four major groups of Medicaid beneficiaries in greater detail, it will be helpful to keep in mind what the Medicaid program actually does. It is neither a direct provider of health services nor a subsidy for individuals to purchase insurance or services. Instead, it pays vendors directly to provide certain services to Medicaid enrollees. Like the eligibility requirements, some of the services are mandatory—the

10 “Medicaid Eligibility.”

11 “Medicaid Recipients and Vendor Payments By Maintenance Assistance Status,” Medicaid Table 2, *Ibid*.

12 “Medicaid Eligibility.”

state must pay for them in order to receive federal funds—and some are optional (see box). Most states offer at least some of these optional services, making Medicaid more generous than many private health insurance plans (which often do not cover optometry or dentistry, for example).

As far as the quality of these services go, states have a great deal of leeway—subject to the requirement that the scope of paid-for services be sufficient to "reasonably achieve their purpose." Payments are made by states directly to providers, but cannot be more than the maximum reimbursements set by Washington. Two important price controls should be noted: states cannot charge more than what Medicare would pay for institutional care, and cannot charge less than Medicare would pay for hospice care (for the terminally ill).[13]

States are allowed to charge nominal deductibles or copayments for Medicaid coverage, but in practice this is rare. For one thing, federal law disallows cost sharing for emergency services or family planning. Many Medicaid recipients are also exempt by federal law, including pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and all categorically needy recipients enrolled in managed care programs.[14] These exemptions cover most Medicaid recipients.

C. Disproportionate Share Hospital Payments

Not all Medicaid expenditures are made on behalf of individual enrollees. The program also provides what are called "disproportionate share" payments to compensate hospitals for a part of the uncompensated care they provide to anyone who needs it. In 1995, DSH payments totalled $8.5 billion.[15]

From their inception in the mid-1980s, DSH payments gradually became a major way for state governments to obtain federal funds for non-Medicaid expenditures through a complicated scheme of bait-and-switch. States would levy taxes on hospital or physician services paid for by Medicaid, bill Washington for their part of the increased Medicaid costs, then give part of the "tax revenue" back the hospitals while keeping the remainder for general state use.[16] In 1991, Congress curtailed the practice but failed to close a similar loophole involving state-owned hospitals.[17]

Subsequent legislation has still failed to fully end the practice of states using the Medicaid system as a source of general funds. Nor has it grappled more generally with the intentions and effects of DSH payments, which has contributed to a high degree of dependency on federal funds by many hospitals, particularly those in urban areas. Public hospitals in the 100 largest U.S. cities now receive 35 percent of their revenues from Medicaid.[18]

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13 "Medicaid Services."

14 *Ibid.*

15 James R. Cantwell, "Reforming Medicaid," *Policy Report No. 197*, National Center for Policy Analysis, August 1995, p. 10.

16 Joseph P. Shapiro, "How states cook the books," *U.S. News & World Report*, July 29, 1991, p. 24.

17 George Anders, "Health-Care Fund Fight Erupts Over States' Use of the Federal 'Disproportionate Share' Clause," *The Wall Street Journal*, June 3, 1993, p. A16.

18 Laurie Abraham, "Tough times ahead," *Business & Health*, vol. 14, Annual 1996, pp.59–65.

Medicaid Services

According to the Health Care Financing Authority, which administers Medicaid, recipients who qualify as categorically needy are entitled to the following:

- Inpatient and outpatient hospital services.
- Physician services.
- Medical and surgical dental services.
- Nursing facility services for those 21 and older.
- Home health care for persons eligible for nursing facility services.
- Birth control services and supplies.
- Rural health clinic services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse midwife services.
- Early and periodic screening, diagnosis and treatment services for individuals under age 21.

In states that cover the medically needy as well, the following is mandatory:

- Prenatal care and delivery services for pregnant women.
- Ambulatory services to individuals under age 18 and those entitled to institutional services.
- Home health services to individuals entitled to nursing facility services.
- Specific services for the mentally ill and mentally retarded.

In addition to these mandated services for which Medicaid must pay, states can elect to add the following (with federal matching funds):

- Clinic services.
- Nursing facility services for those under age 21.
- Other services for the mentally retarded.
- Optometrist services and eyeglasses.
- Prescription drugs.
- Tuberculosis services.
- Prosthetic devices.
- Dental services.

Part 3

Medicaid as Four Separate Programs

If one carefully examines the wide variety of ways in which individuals can qualify for Medicaid, as well as the kinds of services they can receive, it becomes quickly obvious that talking about "Medicaid" as if it were a discrete program with clear goals or objectives is nonsensical. A helpful model for studying Medicaid might be to think of it in terms of four separate programs.

A. Health Insurance for the Non-Elderly Poor

This was a core purpose of Medicaid and remains its image among many policymakers, reporters, and the general public. This image is not unjustified. As of 1995, nearly half of all Medicaid recipients were enrolled in AFDC. Indeed, the largest single group of Medicaid recipients are children automatically eligible via AFDC, who accounted for 24 percent of the caseload.[19] However, adults and children on AFDC, while numerous, do not account for a large share of Medicaid expenditures. Nationally, Medicaid costs average about $1,000 per child and $1,700 per AFDC adult. But the elderly cost an average of $8,704 and the disabled $7,216.[20] The aged, blind, and disabled represent only 27 percent of the caseload but account for the majority of expenditures.[21] (See Figure 2)

There are two factors to keep in mind when thinking about the size of this population of Medicaid recipients. One is that these numbers are merely averages. In fact, the breakdown of recipients and expenditures by category varies widely among the states. Second, long-term trends in the proportion of expenditures or recipients represented by AFDC are tricky to identify because of changes in eligibility that have moved both women and children into different categories in recent years.

Policy Implications. The key fact to recognize about this largest segment of the Medicaid population is that it represents people who may have health needs, but whose more fundamental problem is dependency on public assistance. They need help getting back on their feet, learning new skills or self-discipline, getting off drugs, and becoming more responsible. Because virtually all AFDC recipients are on Medicaid, and more than 80 percent receive Food Stamps, it is instructive to think about these three programs as the "standard package" of public

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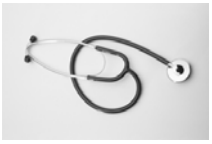
19 There were 17.2 million nondisabled children served by Medicaid in 1995, of which half became eligible via AFDC. Judy Waxman and Joan Alker, "The Impact of Federal Welfare Reform on Medicaid," *Families USA*, Washington, D.C., August 19, 1996, p. 2.

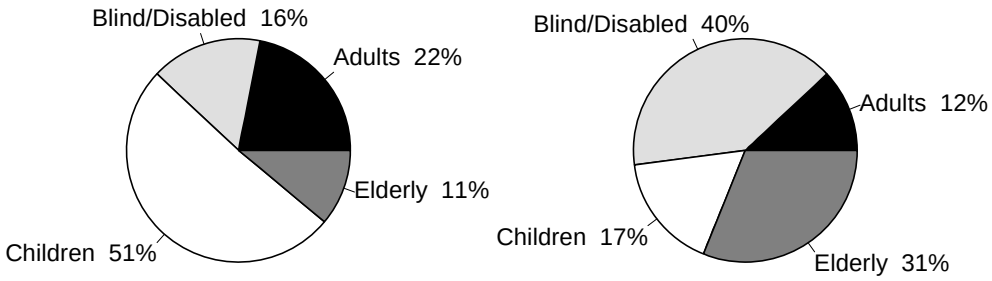
20 Penelope Lemov, "The Medicaid Numbers Game," *Governing*, May 1995, p. 27.

21 "The Medicaid Program," Web Page, HCFA Web Site, updated September 11, 1996.

assistance benefits available to the able-bodied poor. For someone receiving this package in the median state in 1995, Medicaid accounted for more than 40 percent of the total value.[22]

Figure 2: 1995 Medicaid Enrollees and Vendor Payments





Source: Health Care Financing Administration

B. Health Insurance for Non-Poor Pregnant Women and Children

A series of federal and state actions throughout the 1980s and early 1990s progressively expanded Medicaid to cover more pregnant women and children whose family incomes were above the poverty line and thus too high to qualify through AFDC. Some of these expansions had their origins in efforts to reduce infant mortality, for which a government guarantee of prenatal and postnatal care was deemed essential.[23] Another factor was a 1990 U.S. Supreme Court decision that loosened SSI eligibility for children, increasing the number of "disabled" children from non-poor families who qualified for SSI cash payments and thus for Medicaid.[24] At about the same time, the Social Security Administration changed its regulations regarding childhood mental impairment, accounting for another surge in childhood SSI and Medicaid caseloads.[25]

The effects of these decisions can be seen in the fact that the number of Medicaid recipients under age 21 roughly doubled from 9.8 million in 1985 to 18.7 million in 1995, growing much faster than the number of children in poverty. About half of these children became eligible for Medicaid in ways other than being enrolled in AFDC.[26] Overall, one out of every five children in the nation is currently enrolled in the Medicaid

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22 Michael Tanner, Stephen Moore, and David Hartman, "The Work vs. Welfare Trade-Off," *Policy Analysis No. 240*, The Cato Institute, Washington, D.C., September 19, 1995, pp. 8–12.

23 Jane Huntington and Frederick Connell, "For Every Dollar Spent—The Cost-Savings Argument for Prenatal Care," *The New England Journal of Medicine*, vol. 331, no. 19, November 10, 1994, pp. 1303–1307.

24 Lemov, "The Medicaid Numbers Game," p. 28.

25 Christopher M. Wright, "SSI: The Black Hole of the Welfare State," Policy Analysis No. 224, The Cato Institute, April 27, 1995, p. 5.

26 Waxman and Alker, "The Impact of Federal Welfare Reform on Medicaid," p. 2.

program. About one-third of all births in the U.S. are paid for by Medicaid, and the percentage is closer to one-half in some states.[27]

It seems reasonable to distinguish between 1) children whose living standards are above the poverty line and ineligible for AFDC from 2) those who live in welfare-dependent families. One might object that a child or pregnant woman with income below 185 percent of the federal poverty level is certainly living on modest means. That is true. But if the poverty line or eligibility for cash welfare payments is not to be the test for Medicaid eligibility, it is difficult to see how an objective standard for able-bodied children or adults might be set. Indeed, many public officials view the recent expansions as just the beginning of a process to ensure health insurance coverage for all children, regardless of income or disability.[28]

One out of every five children in the nation is currently enrolled in the Medicaid program. About one-third of all births in the U.S. are paid for by Medicaid, and the percentage is closer to one-half in some states.

Policy Implications. Unlike welfare recipients, non-poor pregnant women and children do not receive health insurance on condition of generalized dependency. Lawmakers have provided these non-poor recipients with free health insurance either because of a belief that health care is a right, especially for children, or because of a prediction that Medicaid coverage will be less expensive to the government in the long-run than problematic births and untreated infant diseases. The assumptions behind this latter belief will be examined in great detail later.

C. Long-Term Medical and Custodial Care for the Disabled

This population of Medicaid recipients is perhaps the least familiar to the general public, but it is the most costly. In 1995, 40 percent of all Medicaid vendor payments were for the non-elderly blind or disabled, representing the largest share of Medicaid spending—despite the fact that the disabled represent only 16 percent of total recipients.[29] Some of the cost comes from providing long-term care services—nursing homes, personal care, home health, or intermediate care facilities for the mentally retarded. Although long-term care is often thought of as an issue only for elderly recipients, only 60 percent of long-term care expenditures are made on their behalf. Most of the rest involves non-elderly disabled recipients.[30]

The composition of the more than 10 million disabled Americans on Medicaid is diverse, including adults with severe physical conditions and handicaps, AIDS, mental illness, and mental retardation. About one-tenth of the population is made up of children.[31]

The major route through which the disabled enroll in Medicaid is through SSI eligibility. SSI was created in 1972 as Title XVI of the Social Security Act and began operating in 1974. It is a means-tested cash-assistance welfare program for low-income aged, blind, and disabled persons. As with Medicaid, SSI was

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27 "The Medicaid Program."

28 Susan Dentzer, "For mercy's sake, let's cover kids," *U.S. News & World Report*, October 21, 1996, p. 69.

29 The Twentieth Century Fund, *Medicare Reform: A Twentieth Century Fund Guide to the Issues* (New York: Twentieth Century Fund Press, 1995), Figures F and G.

30 Joshua M. Wiener, "Can Medicaid Long-Term Care Expenditures for the Elderly be Reduced?" The Commonwealth Fund, New York, N.Y., June 1996, p. 1.

31 "The Impact of Children's SSI Program Changes in Welfare Reform," Brazelton Center for Mental Health Law, Washington, D.C., August 7, 1996, p. 1.

intended to supplement or supplant previous state-funded efforts to provide income maintenance for the elderly poor and disabled (such "special assistance" programs still exist in many states, however). While the program was sold in 1972 as an incremental extension of the Social Security retirement system, it now serves more disabled people, including children, then seniors.[32]

In 1994, one-third of all Medicaid expenditures were for the non-elderly blind or disabled, representing the largest share of Medicaid spending—despite the fact that the disabled represent only 16 percent of total recipients.

Policy Implications. First, the disabled portion of the Medicaid population is a "catch-all" category that includes individuals who are essentially permanent "wards of the state" with serious and incurable diseases or disabilities, as well as those with temporary injuries or conditions, those with substance abuse or mental health conditions, and children with conditions ranging from severe physical and mental deformities to relatively mild behavioral problems. Second, the disabled are, on average, the costliest Medicaid recipients per-capita. Third, through vendor payments for disabled persons (and the elderly), the Medicaid system has become a significant and sometimes dominant funder of public hospitals, mental hospitals, intermediate care facilities, and nursing homes.[33]

D. Long-Term Medical and Custodial Care for the Elderly

Medicaid was established in 1965 in response to the perceived inadequacy of the "welfare medical care" under public assistance programs.[34] There was virtually no discussion about the role Medicaid might play in paying for long-term services such as nursing home care for the elderly, particularly the non-poor elderly.

In 1995, 33 percent of Medicaid expenditures were for long-term care expenses. In 12 states, long-term care accounts for 45 percent or more of Medicaid expenditures.[35] While only 5 percent of recipients were residents of nursing homes in 1995, they accounted for a quarter of all Medicaid payments to vendors.[36] The program has become the largest single funder of long-term care expenses in the United States, including those for middle-class Americans. Medicaid pays over 50 percent of all nursing home costs in the U.S. and pays at least part of the bill for 68 percent of all nursing home residents (see Figure 3).[37]

In one sense, of course, the "elderly" do not consume long-term care: a subset of seniors with a serious medical condition or disability do. One might even consider elderly and disabled Medicaid recipients as one group, in that they are often consuming similar services and have become eligible in similar ways. But there is an important difference. The percentage of children or adults under 65 who are born with or develop serious medical conditions or disabilities is not very high. The kind of disability that makes one a permanent "ward of the state" for all practical purposes is rare.

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32 Wright, "SSI," p. 5.

33 See Jerome Kassirer, "Our Ailing Public Hospitals: Cure Them or Close Them?" *The New England Journal of Medicine*, vol. 333, no. 20, November 16, 1995, p. 1348-1349.

34 "Brief Summaries."

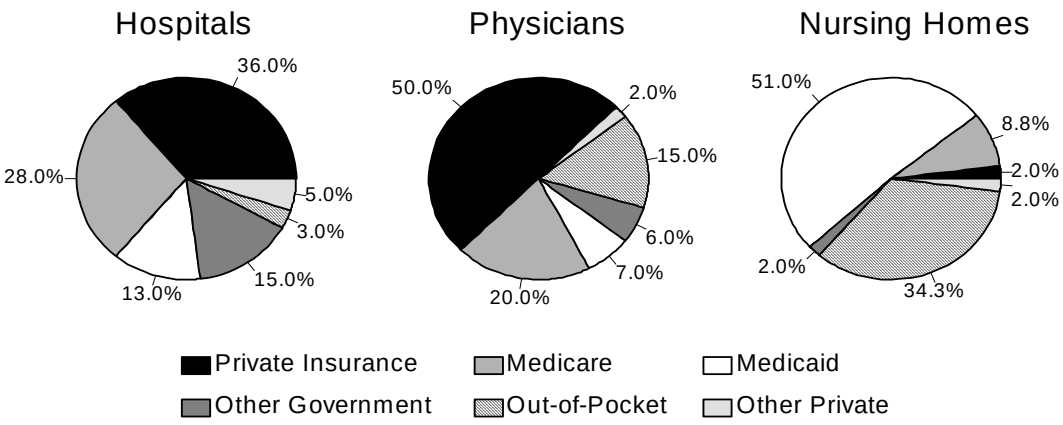
35 Wiener, "Can Medicaid Long-Term Care Expenditures," p. 2.

36 "Medicaid Vendor Payments by Type of Service," Medicaid Table 5, Data and Statistics Page, HCFA Web Site, updated October 18, 1996.

37 "The Medicaid Program," p. 1.

But as an individual ages, the probability of developing conditions serious enough to warrant long-term care of some kind increases. More than 40 percent of those who turn 65 will spend some time in a nursing home. Of those who enter a nursing home, 55 percent will stay at least a year and 21 percent—or nearly a tenth of all seniors—will remain longer than five years (see Figure 4).[38] For someone approaching retirement, in other words, the chances are almost 50-50 of facing some nursing home bills, and even higher that he or she will incur long-term care expenses of some kind including home health care. That surely places the elderly in a different situation than a child born with a congenital mental defect or an adult paralyzed in a traffic accident.

Figure 3: Breakdowns for Medical Providers, 1995



Source: *Business and Health*, 1996.

Nursing home and other long-term care needs are not the only expenses for which the elderly are eligible. For certain poor Medicare recipients, known as "Qualified Medicare Beneficiaries," Medicaid pays the premiums for Medicare Part B (physician services) and any deductibles or copayments for Part A (hospital services). Yet another group, called "Specified Low-Income Medicare Beneficiaries, Medicaid pays only the Part B premiums. Overall, persons aged 65 and older in 1995 made up about 11 percent of Medicaid recipients, but were responsible for about 31 percent of vendor payments.[39]

Policy Implications. The elderly Medicaid population is made up of millions of Americans who have been "middle class" throughout most of their lives. Many have transferred their assets to their families in order to qualify for Medicaid subsidies, and indeed there is a massive body of literature available in any local public library that describes exactly how to evade asset limits and income tests to gain Medicaid eligibility. Very few of the elderly actually "spend down" most of their assets before going on Medicaid, only 10 percent of those in nursing homes according to a Congressional Budget Office study.[40] The remaining caseload of elderly nursing home residents on

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38 "Examining Long-Term Care," Research in Action Page, Agency for Health Care Policy Research Web Site, U.S. Department of Health and Human Services, updated February 22, 1996.

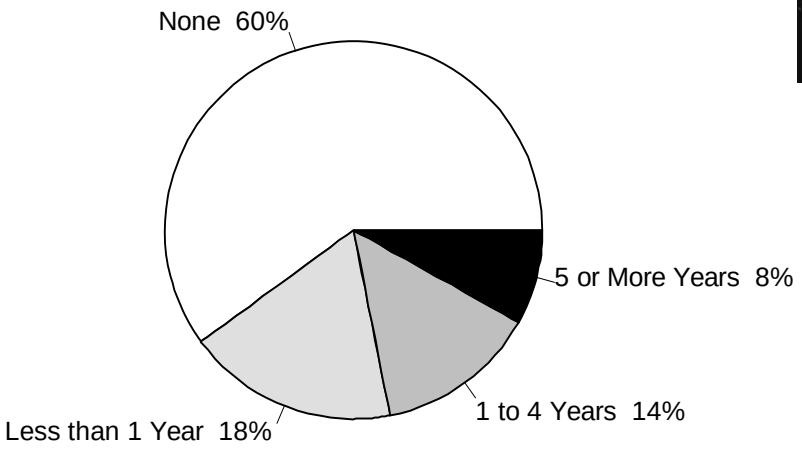
39 *Medicaid Reform*.

40 John Merline, "Time to Plan Ahead for Long-Term Care," *Consumers' Research*, January 1996, p. 13.

Medicaid are receiving a middle-class entitlement by shielding their assets in some fashion or passing them on to heirs before, rather than after, death. For individual families, taking advantage of this opportunity to preserve the value of family assets no doubt seems like a reasonable course. However, passing the costs of long-term care for middle-class seniors onto the general population, including unrelated young workers of modest means, poses serious problems of fairness and equity.

Figure 4: Chances of Entering a Nursing Home at Age 65

% of Those Aged 65



Source: *New England Journal of Medicine*, 1991.

A second point to remember is that in the 1960s, when Medicaid was enacted, the life expectancy of older adults, and thus the percentage of the population living long enough to need long-term care, was lower than it is now. The increased need for such care is in part the happy result of the fact that a combination of economic improvements and medical advances has improved the prospects of living to a ripe old age. Instead of dying at 50 of a stroke or heart attack, a person might live to be 85 or 90, albeit perhaps spending the last couple of years of life in a nursing home.

Passing the costs of long-term care for middle-class seniors onto the general population, including unrelated young workers of modest means, poses serious problems of fairness and equity.

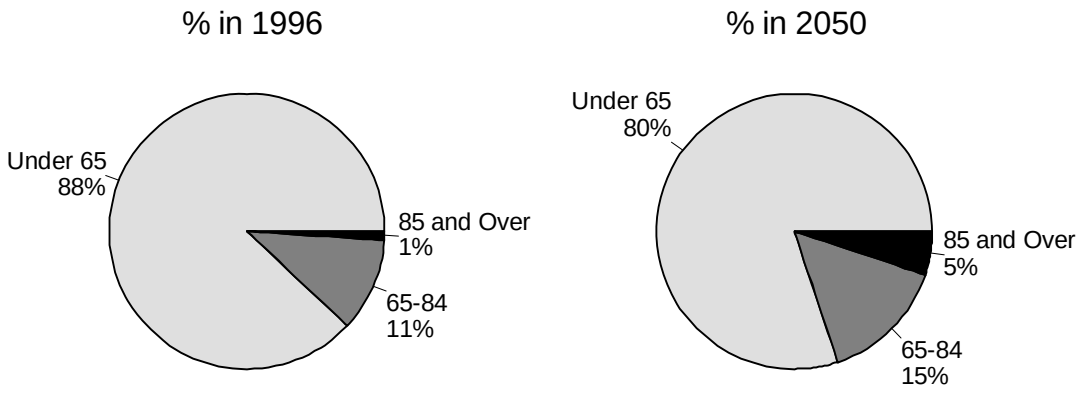
Demographics, in other words, have great implications not just for the cost of Medicaid but the very sustainability of the program in a future very different from that experienced when the program was enacted. Between 1960 and 1994, the general population of the United States grew by 45 percent. But the population aged 65 and older doubled and the over-85 population grew by 274 percent, to 3 million. This "oldest of the old" population now makes up a 10th of the elderly population, but will be a fourth by the middle of the next century (see Figure 5). While only 1 percent of those aged 65 to 74 are in nursing homes, 25 percent of those 85

and older are.[41] This group, only three percent of Medicaid recipients, accounts for 13 percent of all Medicaid payments to vendors and costs far more per average person ($13,406 in 1995) than any other group.[42]

As both the elderly population in general continues to grow relative to the number of workers, open-ended entitlements to long-term care (not to mention Social Security and Medicare) will simply become unaffordable.

More generally, while only about 10 percent of those aged 65 to 74 need assistance with everyday activities such as bathing or eating, fully half of those aged 85 and older do.[43] As both the elderly population in general—and the core 85-and-over population most needing medical and custodial services—continues to grow relative to the number of workers, open-ended entitlements to long-term care (not to mention Social Security and Medicare) will simply become unaffordable.

Figure 5: Expected Change in Elderly Share of Population



Source: U.S. Census Bureau

41 "Sixty-Five Plus in the United States," *Statistical Brief*, U.S. Census Bureau, Economics and Statistics Administration, U.S. Department of Commerce, May 1995.

42 "Medicaid Recipients and Vendor Payments by Age," Medicaid Table 6, Data and Statistics Page, HCFA Web Site, updated October 18, 1996.

43 "Sixty-Five Plus in the United States."

Part 4

The Need for Medicaid Reform

While most lawmakers and observers believe that the Medicaid program needs reform, they may differ substantially about why reform is needed and what course it should take. In truth, there are several distinct yet related reasons why the program is unsustainable in its current form. I view the following issues as most pressing.

A. Problem #1: Cost

The federal budget crisis is caused to a large degree by explosive growth in entitlements. In FY 1994, federal expenditures for Social Security, Medicare, and Medicaid made up 40 percent of the budget—a larger share than all discretionary spending for domestic, defense, and foreign aid programs combined.[44] That percentage will grow in the future as the population ages, necessitating huge tax increases on a diminishing proportion of workers unless the programs are changed in some way. Just from 1996 to 2000, the Census Bureau projects a 22 percent increase in the number of elderly living in nursing homes, a factor likely to keep Medicaid growing at 10 percent or more a year.[45]

As this paper covers Medicaid and is addressed primarily to state lawmakers and policymakers, the impact of the program on state budgets deserve closer scrutiny. The portion of Medicaid paid by Washington is called the Federal Medical Assistance Percentage (FMAP). It is determined annually for each state by a formula that compares the state's average per-capita income level with the national average. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. Overall, the federal government paid about 54 percent of program (non-administrative) costs in 1995, with the states picking up about 45 percent (the small remainder being shouldered by counties in some states).[46]

In 1970, when Medicaid was five years old, it consumed only four percent of the average state budget. That percentage has steadily grown since then, reaching 10 percent by 1985 and 19 percent by 1995. For the average state today, Medicaid expenditures are nearly as large a share of total state spending as K-12 education and much larger than spending for higher education, transportation, or corrections.[47] (See Figure 6) Whether paid for by federal taxes or state taxes, of course, this expansion in Medicaid has resulted in less money available for family needs or other government expenditures.

Part of the cause of Medicaid's cost explosion has been the eligibility expansion detailed earlier. But another cause is the design of the program itself, which encourages unnecessary, expensive medical consumption.

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[44] *Medicaid Reform*, Figure A.

[45] Paul Magnusson, "Medicaid Is Getting Tough With Granny," *Business Week*, September 30, 1996.

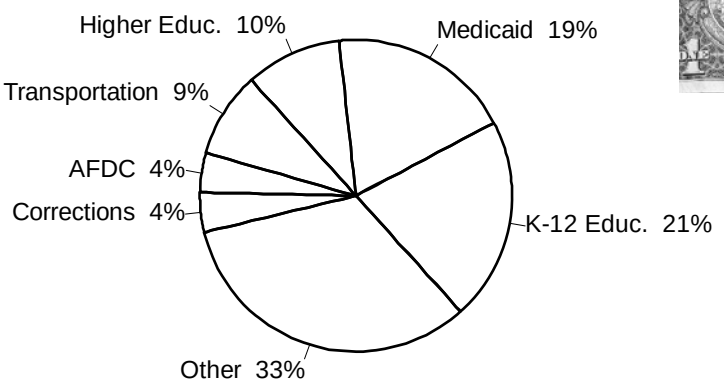
[46] "Medicaid Services."

[47] Data obtained from Health Care Financing Administration.

Because Medicaid recipients pay little or nothing out-of-pocket to obtain health care services, they tend to be frequent users of the system—and often choose convenient but costly care at hospital emergency rooms rather than less immediate care at doctors' offices. Studies show that Medicaid recipients use health care services more often than do patients with private health insurance (who face out-of-pocket costs or other incentives to consume medical care more efficiently).[48] However, the difference in utilization between the two groups is much smaller in studies that carefully adjust for other factors, such as health status.[49]

For the average state today, Medicaid expenditures are nearly as large a share of total state spending as K-12 education and much larger than spending for higher education, transportation, or corrections.

Figure 6: Medicaid vs. Other State Spending



Source: Health Care Financing Administration

One further reason for the high cost of Medicaid is that the program covers payments to such providers as chiropractors, optometrists, podiatrists, and dentists, even though the health insurance many American families buy individually or through their employers does not include such coverage. Furthermore, this expansive coverage includes the kinds of coverage that lend themselves to the most over-consumption due to complete third-party payment of medical bills.[50]

Finally, the disabled and elderly Medicaid population, which account for most spending on the program, will likely need more expensive care than the average insured American regardless of what reforms are enacted.

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48 H.E. Freeman and C.R. Corey, "Insurance Status and Access to Health Services Among Poor Persons," *Health Services Research*, Vol. 28, no. 5, December 1993, pp. 531–542.

49 M. Susan Marquis and Stephen H. Long, "Reconsidering the effect of Medicaid on health care services use," *Health Services Research*, Vol. 30, no. 6, February 1996, pp. 791-819.

50 John Goodman, editor, *Health Care Briefing Book for Legislative Candidates*, National Center for Policy Analysis, Dallas, 1994, p. 4.

Their care involves more equipment, more specialists, and more intensive monitoring. Nursing home stays average about $40,000 a year, for example.[51]

Problem #2: Mismatch of Means and Ends

Most Medicaid recipients are eligible for the program because they are enrolled in a cash welfare program such as AFDC. But since Medicaid is provided in the form of health insurance, rather than cash, recipients can benefit from Medicaid only by consuming health care. If they choose not to obtain a particular service, or choose a lower-cost provider of the service, they do not get to keep the savings to purchase something they need or value more. And unlike those who buy private health insurance, Medicaid recipients cannot enroll in health insurance plans covering fewer services or procedures than Medicaid and then use the premium savings for something else.

State occupational licensing restrictions keep patients from receiving less expensive and perhaps more personal care from nurse practitioners or other non-physician providers.

This "use it or lose it" aspect of Medicaid not only increases health care consumption and the total cost of the program—as argued above—but also expends scarce public assistance dollars in ways that do not serve the overall needs of recipients in the long run. Since Medicaid makes up the largest component of the standard package of welfare benefits, its inflexible design prevents recipients from using a significant part of the public assistance spending they are eligible to receive to develop the occupational skills, literacy, savings, or assets they require to become self-sufficient.

A similar "use it or lose it" dynamic encourages some disabled or elderly recipients and their families to choose institutional long-term care over other arrangements, such as home-based care or assisted-living group homes, that may cost less and may be more desirable for many families—but which do not receive the same value of subsidy from Medicaid.[52]

Problem #3: Quality of Care

It is quite possible for a good or service to cost more than alternatives while at the same time be of lower quality. Often, the issue is not the price of the good or service but who pays it. Generally speaking, consumers spending their own money at least in part are more likely to gather information about alternatives. This added information and decisionmaking authority doesn't just increase the chances of cost savings but also the chances of finding a provider who better meets the consumer's needs.

Of this problem, the Medicaid system is the classic example. It pays all bills on behalf of its customers and is thus a "third-party payer" that both spends a lot of money in general and stiffs vendors in particular. Reimbursements rates for Medicaid services ranging from routine care to hospitalization are often lower than those of private payers or Medicare, though this is not always true for every service in every state. Either because of low reimbursement rates or other perceptions of problems associated with Medicaid patients, only

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[51] Winthrop S. Cashdollar, "Rethinking the Federal Role in Long-Term Care," *Common Sense*, Spring 1995, p. 88.

[52] "A Long-Term Solution to a Medicaid Problem," Brief Analysis No. 190, National Center for Policy Analysis, November 17, 1995.

34 percent of physicians surveyed by the American Medical Association in 1991 said they fully participated in Medicaid. Another 35 percent participated minimally, while 26 percent said they didn't accept Medicaid patients and another 5 percent said they had Medicaid patients but wouldn't take any more.[53] While patients in traditional fee-for-service Medicaid have a theoretical right to choose their medical providers, their choice is effectively limited by physician unwillingness to participate.

This promise of free or subsidized long-term care not only discourages personal responsibility but leads to an immoral transfer of money from current taxpayers to older, solidly middle-class, Medicaid recipients.

Another reason for Medicaid recipients' inability to choose among alternative providers is government regulation. State occupational licensing restrictions keep patients from receiving less expensive and perhaps more personal care from nurse practitioners or other non-physician providers.[54] Furthermore, most states strictly limit the number of nursing homes and other institutional providers of care through a certificate-of-need process. States say that if more nursing home beds were available, they would be filled by more Medicaid recipients costing taxpayers more money—which may well be true, given the current entitlement nature of the program —but the inevitable result of limiting supply is that there is little selection and long waiting lists for nursing homes in many jurisdictions.[55] Naturally, such a lack of competition has negative effects on quality and consumer satisfaction.

Problem #4: Personal Responsibility

There is also a place for moral argument concerning the Medicaid explosion. If the concept of limited government is to retain any meaning at all, then we must expect citizens to take responsibility for their actions and to make reasonable arrangements for their future needs. For adults, the prospect of incurring significant health costs as they age, including long-term care costs in their old age, should be no surprise. Many have seen friends or their own parents go through disability or debilitating illness.

It is true that until recently, private long-term care insurance was neither widely available nor tax-deductible. Our tax code has also punished those who save for future medical needs rather than spend income today. Setting aside for the moment tax changes to treat medical savings and long-term care insurance more fairly, the most likely reason why people don't plan ahead for future medical needs is that they know those needs, if serious enough, will be picked up by the government through the Medicaid system.[56]

This promise of free or subsidized long-term care not only discourages personal responsibility but leads to an immoral transfer of money from current taxpayers, many young and of extremely modest means, to older Medicaid recipients who are, in many cases, solidly middle-class in background and family assets. Even if this practice were sustainable—and because of changing ratios of retirees to workers, it is not—it would be wrong.

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53 *Medicaid Reform*, Figure L.

54 Occupational licensing cite.

55 Merline, "Time to Plan Ahead," p. 11.

56 Jane Bryant Quinn, "Long-Term Care Insurance Looking Better," *Newsweek*, September 30, 1996, p. 53.

Part 5

Medicaid and Managed Care

Surveying the cost explosion and other problems facing Medicaid, many state and federal lawmakers have turned to managed care as a way to rein in expenses. This is not surprising. Private employers have been flocking to health maintenance organizations (HMOs) and other managed care networks to reduce health care costs for their workers. Furthermore, many governments have been experimenting in general with contracting out services to competing private providers, so Medicaid managed care appears to be simply an extension of the privatization trend making its way through cities, counties, states, and even the federal bureaucracy.

State experience to date with Medicaid managed care is analyzed below. A word of caution is warranted, however; for the vast majority of states currently using managed care to deliver Medicaid, the experience with widespread contracting is so new that firm conclusions about costs or quality of care are impossible to draw. An exception is Arizona, which has had a managed care system in place since 1982. Consequently, it receives much of the attention in this section.

A. The Advent of Managed Care

Enrolling Medicaid recipients in HMOs is not a new idea. Washington state began contracting with Group Health of Puget Sound in 1970 and New York City Medicaid beneficiaries were enrolled in the HMO-like Health Insurance Plan of Greater New York the same year. But these plans involved relatively few recipients. The first broad use of managed care contracts for Medicaid appeared in Arizona in 1982, with the creation of the Arizona Health Care Cost Containment System (AHCCCS). [57]

Still, by 1991 there were only 2.7 million Medicaid recipients, or 8 percent of the total U.S. caseload, enrolled in managed care. Since that year, the growth of Medicaid managed care has been rapid. One might even call it abrupt. By 1995, managed care enrollees had more than quadrupled to 11.6 million, or 28 percent of all recipients.[58] Preliminary data for 1996 shows that one-third of all Medicaid recipients may now be enrolled in some form of managed care.[59] Not all managed care is created equal, however. About half of managed care enrollees in 1994 (the last year for which unduplicated numbers are available) were in HMOs, called the "strongest" type by analysts because it provides a straight per-person (or "capitated") rate to providers, from which the latter must pay for necessary services and make money. The providers, in other

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[57] Laura Tobler and Dianna Gordon, "Will managed care be Jekyl or Hyde for states?" *State Legislatures*, July-August 1996, p. 59.

[58] "National Summary of Medicaid Managed Care Programs and Enrollment as of June 30 of each Year," Medicaid Table 11, Data and Statistics Page, HCFA Web Site, updated October 18, 1996.

[59] Leigh Page, "States cautious of jumping into Medicaid managed care," *American Medical News*, September 2, 1996, p. 6.

words, bear the "insurance risk." Another third of Medicaid managed care is in the form of Personal Care Casement Management (PCCM), in which providers are compensated according to services rendered plus a capitation for managing the care of patients. In that instance, then, the insurance risk remains with the payer. The remainder of the Medicaid population is in other managed care networks.[60]

Figure 7: Number of Medicaid Enrollees in Managed Care

Source: National Summary of Medicaid Managed Care Programs, HCFA Web site.

All but two states, Alaska and Wyoming, have adopted some type of Medicaid managed care. State experiences differ substantially, depending on how long the program has been in place and its specific design, but several general observations can be made:

1. Medicaid managed care affects mostly the non-disabled, non-elderly portion of the caseload.

Most state programs either specifically exclude the disabled and elderly population or discourage these groups from participating. So the experience to date largely involves AFDC recipients and other near-poor mothers and children.[61]

2. On balance, managed care for this population does appear to save program costs over traditional fee-for-service medicine, at least initially.

The Kaiser Commission for the Future of Medicaid surveyed research on managed care and concluded the range of possible savings was from 5 percent 15 percent. Savings may come from a decline in the inappropriate use of emergency rooms, but not in reduced visits to doctors' offices, for which there is little evidence.[62] Florida and Michigan, for example, experienced savings of 8 to 10 percent after two years of managed care Medicaid, close to the mid-point of the range, with Michigan seeing a 25 percent drop in

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60 "National Summary of Medicaid Managed Care."

61 Page.

62 Tobler and Gordon, "Will managed care be Jekyl or Hyde for states?," p. 61.

inappropriate emergency room visits.[63] But a 1996 study of Medicaid managed care in New York City found no significant change in either emergency room use or cost.[64]

Table 2: Managed Care Savings		
Savings	City or State	Source
5–15%	N/A	Kaiser Commission for the Future of Medicaid. See footnote 57
8–10%	Florida and Michigan	Lemov, "The Medicaid Numbers Game," p. 28.
No significant change	New York City, New York	Jane Sisk, et al., "Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use," *The Journal of the American Medical Association*, vol. 276, no. 1, July 3, 1996, p. 50.

An immediate savings of up to 15 percent in state Medicaid programs would be consistent with how managed care has affected private health care costs. Managed care typically results in a short-term reduction in per-enrollee costs vs. fee-for-service, but that is often followed by annual cost increases not much different than that of traditional indemnity plans.[65]

In the case of Medicaid, few programs have been around long enough to evaluate the long-range cost implications. Even in Arizona, the record is mixed. From 1983 to 1991, AHCCCS per-capita costs rose at about the same rate as fee-for-service Medicaid would have for AFDC-eligible recipients. But the cost increase *was* lower, particularly from 1987 on, for SSI-eligible disabled recipients—one of the groups so far left out of most managed care experiments.[66]

3. Quality of services under Medicaid managed care has remained about the same overall, improving in some states but seeming to deteriorate in others.[67]

Some studies of consumer satisfaction show HMO enrollees to rate their care better than fee-for-service peers.[68] The 1996 study of New York City's experience found that managed care enrollees "gave higher ratings of satisfaction" than those in traditional Medicaid. The authors pointed out that, unlike other insured individuals moving from fee-for-service to managed care, Medicaid recipients have historically had trouble choosing their own doctor and accessing care because of low reimbursement rates or other physician perceptions that discourage them from accepting Medicaid patients. So for many Medicaid patients in markets where physician participation in traditional Medicaid is low, managed care may be an improvement even if it isn't for the general population.[69]

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63 Lemov, "The Medicaid Numbers Game," p. 28.

64 Jane Sisk, Sheila A. Gorman, Anne Lenhard Reisinger, Sherry A. Glied, William H. DuMouchel and Margaret M. Hynes, "Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use," *The Journal of the American Medical Association*, vol. 276, no. 1, July 3, 1996, p. 50.

65 This issue is discussed in Milt Freudenheim, "Health Care Economists Dispute Savings From HMOs," *The New York Times*, September 5, 1994, p. 4A; and John Merline, "Making Money By Denying Health Care," *Consumers' Research*, September 1994, p. 13.

66 "Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs," General Accounting Office Report to the Chairman, Committee on Commerce, U.S. House of Representatives, GAO/HEHS-96-2, October 1995, pp. 7–9.

67 Tobler and Gordon, "Will managed care be Jekyl or Hyde for states?"

68 David Jacobsen, "Cost-Conscious Care," *Reason*, June 1996, p. 51.

69 Sisk, et. al., "Evaluation of Medicaid Managed Care."

On the other hand, detractors of managed care complain that HMOs routinely deny care to those who need it, in effect substituting the financial judgment of corporate reviewers for the medical judgment of physicians.[70] There is some evidence to believe that this "gatekeeping" function of managed care may cause more problems for Medicaid patients than for the general population. One study of patients in Chicago, Los Angeles, and Boston found that poor and elderly people with chronic conditions seemed to fare much worse under managed care than similar patients in traditional fee-for-service plans. Twice as many poor and elderly patients in managed care said their health declined during a four-year period as did those in fee-for-service plans.[71] A report to Congress by the Physician Payment Review Commission argued that "the risk of underservice may be greater with Medicaid patients because they appear to have less ability to 'work the system.'"[72]

B. Case Study: Arizona

While having the longest—and thus most educational—experience with Medicaid managed care, Arizona was the last state to create a Medicaid program. It chose not to join when the program was created in the mid-1960s, and retained a system of indigent care based on county governments and public hospitals, as most states had done before Medicaid. A state budget crisis fostered by the 1980 recession led state lawmakers to decide to devise a new system for attracting federal Medicaid dollars while avoiding the costs and headaches other states were experiencing with traditional fee-for-service programs. In 1981, the legislature created AHCCCS and a year later received a waiver from the federal government to put it into place.[73]

From the start, AHCCCS was a prepaid, capitated program awarding contracts to competing public and private health plans to provide medical services. It required a federal waiver not simply to implement managed care, but to exclude beneficiaries other than the categorically needy (AFDC and SSI recipients) and to exclude services such as nursing homes, home health, family planning, and nonacute mental health. Over time, however, other groups were added to the eligibility list, including near-poor pregnant women and children and the medically needy.

The program's competitive bidding process has evolved over time, in response to experience and to some criticisms, but the core has remained the same. Health plans submit initial bids for a limited number of Medicaid contracts in each of the state's 15 counties. After some feedback from AHCCCS, they can submit a second bid. Both bids are, however, considered in awarding contracts, so that a plan that has submitted a high initial bid will be at a disadvantage compared with a competitor that submitted a low initial bid, even if their final bids are identical.

AHCCCS doesn't simply take the lowest bids. During each two-year contract period, the program gathers utilization, cost, and profit data from the health plans currently serving Medicaid recipients and distributes it to all potential bidders. Using the data, it employs independent actuaries to construct a reasonable "bid range" that is kept secret from bidders. (AHCCS excludes bids that fall below this range as being

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70 See, for example, Jeanne Kassler, "Managed Care—Or Chaos," *New York*, August 23, 1993, pp. 45–50; and John Merline, "Making Money By Denying Health Care," *Consumers' Research*, September 1994, pp. 10–15.

71 Lindsey Tanner, "Elderly, poor suffer under managed care," *The Herald-Sun* (Associated Press), October 2, 1996, p. 3A.

72 Greg Borzo, "States trying managed care now, rather than waiting for reform," *American Medical News*, February 8, 1993, p. 33.

73 David Azevedo, "No kidding - there's a state where doctors like Medicaid," *Medical Economics*, vol. 69, no. 24, p. 126.

unsupportable by a health plan's revenue and resources). In considering contract awards, AHCCCS looks not just at bids but at access and quality factors.

In 1994, 21 health plans submitted 95 bids to provide Medicaid services in the 15 counties. Bidders included for-profit and nonprofit plans. AHCCCS awarded a total of 42 contracts. Seven of the 21 bidders, including two previous Medicaid contractors, were awarded no contracts at all. Competition was vigorous not just for the two urban counties but also for the rural areas.[74]

Of course, running an ongoing and complicated bidding process is itself expensive. Some of the cost savings associated with AHCCCS are offset by higher administrative costs for data collection, monitoring, consultants, etc. In 1994, Arizona's administrative costs were 7 percent of the total medical assistance budget, vs. 4 to 5 percent on average in other states. Still, AHCCCS appears to generate net savings. One study found that in 1991, the program cut expenses $71 million below what a traditional Medicaid program would have spent, while requiring an extra $20 million in administration costs. The net savings of nearly $52 million was split between the federal government ($37 million) and the state ($14.5 million).[75]

According to studies by the General Accounting Office and other researchers, the cost containment focus of AHCCCS does not appear to have adversely affected the care provided to most Arizona Medicaid recipients, at least as compared to other state residents in managed care.

According to studies by the General Accounting Office and other researchers, the cost containment focus of AHCCCS does not appear to have adversely affected the care provided to most Arizona Medicaid recipients, at least as compared to other state residents in managed care. One 1995 survey of recipients found that they were just as likely as privately insured patients to say their doctors were easily accessible, listened to them carefully, made sure they understood what they were told, and treated them with dignity and respect. However, the Medicaid patients were three times as likely to report delays in getting services than those enrolled in privately funded managed care.[76]

Two expansions of AHCCCS deserve special attention. When the program was passed as state legislation in 1981, it included a provision allowing private employers with up to 25 employees to purchase health care from AHCCCS. This part of the program was not actually put into place until 1988, and didn't insure that many people until after 1991, when the employee limit was raised to 40. As of 1995, AHCCCS had contracts with four health plans to provide services to 18,000 employees from 5,800 different businesses. The second expansion involved long-term care, which was originally left out of AHCCCS. In 1989, the state created the Arizona Long Term Care System (ALTCS), which offers long-term care, acute care, and home and community-based services to the elderly and physically or developmentally disabled. As of 1995, about 20,000 people were enrolled in ALTCS.

Table 3: A 10-Point Medicaid Reform Plan

74 "Arizona Medicaid," pp. 12–14.

75 *Ibid*., p. 11.

76 "Medicaid Program Enrollees Report As Pleased with Care as Private Plans," *BNA Health Care Daily*, Bureau of National Affairs, January 10, 1996.

Reforms	Constituents
1. Continue to reform welfare	Poor Children and Adults
2. Institute vouchers for nondisabled, nonelderly recipients	
3. Resist expansion of the Medicaid program to able-bodied persons above the poverty line, and attempt where possible to roll back previous expansions.	The Near-Poor Uninsured
4. Enact reforms at the state level to reduce the cost of health insurance and thus the ranks of the uninsured.	
5. Continue to reform disability programs.	The Disabled
6. Tighten state eligibility standards for disability.	
7. Use competition where possible to deliver services more efficiently.	
8. Enforce asset-transfer, asset-recovery, and spousal requirements.	The Elderly
9. Set a date certain after which elderly recipients or their families must pay for their own long-term care expenses.	
10. End disincentives to save and to purchase long-term care insurance.	

A cautionary note. Arizona's innovative Medicaid program has been cited as an example for other states to emulate. But the Arizona program is far from problem-free. Recent reports in the local news media point to a pattern of mismanagement and fraud. A federal investigation into the matter and the early 1996 resignation of the AHCCCS director have focused a great deal of attention on computer problems, benefits being paid to dead residents, and persecution of whistleblowers.[77] Later in 1996, a group called the Healthy Arizona Initiative tried to put an initiative on the November ballot to expand Medicaid eligibility by up to 180,000 citizens. While the effort failed, it received a lot of support from such groups as the American Association of Retired Persons, the American Academy of Family Physicians, the American Academy of Pediatrics, and the National Organization for Women. One argument in favor of the expansion was that it wouldn't require large new expenditures.[78]

C. The Disabled and Elderly

Enrollment of disabled and elderly Medicaid recipients in managed care is rare, and of even more recent vintage than managed care for poor women and children. Therefore, drawing conclusions about the likely effects of managed care on cost and quality is even trickier. Policymakers may have to wait and see how experiments just getting underway with the mentally retarded, the physically disabled, and some elderly nursing home residents turn out.[79] Nevertheless, there are a few programs for which data exist.

One assumption on the part of Medicaid reformers is that integrating acute and long-term care—covered by Medicare and Medicaid, respectively—with managed care would reduce fragmentation and thus improve both quality and efficiency. There are three demonstrations of this approach available for study: the Arizona Long Term Care System (ALTCS), Social Health Maintenance Organizations (Social HMOs), and On Lok Senior Health Services.

1. ALTCS

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77 Bill Muller and Pat Flannery, "AHCCCS Head Quits, Denies U.S. Probe a Factor," *The Arizona Republic*, February 28, 1996, p. A1.

78 Peter MacPherson, "Arizona voters to decide Medicaid expansion," *Hospitals & Health Networks*, May 20, 1996, p. 46.

79 See, for example, "Public Managed Behavioral Health Care Initiatives," Engquist, Perline & Powell Inc., May 13, 1996.

ALTCS works in a similar fashion to AHCCCS, in the sense that it awards prepaid, capitated contracts to provide services. But ALTCS contracts with only one provider per county, rather than two or more as in the case of AHCCCS, and strictly limits participation to individuals who are certified to be at high risk of institutionalization. In the majority of cases, the contractor chosen for elderly people and persons with physical disabilities is a county government. Laguna Research Associates compared the total costs of ATLCS with an estimate of what a traditional Medicaid program in Arizona would cost, and found that the program did appear to save money. For 1993, the researchers estimated that service costs for the elderly population were 18 percent less that they would have been in a traditional Medicaid program. But like AHCCCS, the ATLCS has high administrative costs, offsetting a significant portion of the savings. Moreover, the savings appear to come mostly from tight eligibility standards, which cause ATLCS to serve about 16 percent fewer recipients than would a traditional Medicaid program. As far as per-member per-month costs go, ATLCS was only about two percent lower.[80]

2. Social HMOs

Social HMOs attempt to serve all the medical and institutional needs of elderly recipients in a "one-stop shopping" model. They serve mostly non-disabled elderly persons and are funded mostly by Medicare rather than Medicaid. Studies show that capitation does appear to reduce costs for social HMOs, but whether the integration of acute care and long-term care creates efficiency is not settled. At the same time, these experiments have been characterized by high physician turnover, patient dissatisfaction, and administrative problems. Part of the problem is that physicians are uncomfortable working in teams with other non-medical providers. Another is that patients are not happy about giving up their personal doctors.[81]

3. On Lok/PACE

On Lok Senior Health Services has been operating a capitation program since 1983 using Medicare, Medicaid, and some private funds. The Program for All-Inclusive Care of the Elderly (PACE) has replicated the On Lok approach in 11 small residential sites. Enrollment is limited to individuals who are so disabled that they meet nursing home admission criteria. Research on the cost savings of On Lok/PACE are promising but preliminary, according to Joshua Wiener of The Urban Institute.[82]

To achieve significant savings in Medicaid over the long run, something must be done either to reduce the cost or the number of disabled and elderly recipients.

D. Evaluating Managed Care

While it is too early to know the long-run effects of Medicaid managed care either on costs or on the quality of services delivered, we can draw some conclusions about the role of managed care in Medicaid reform. First, both state policymakers and managed care companies have expressed more willingness to enroll the non-disabled, non-elderly population, which is the most numerous but already the least costly of the

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80 Wiener, "Making Money By Denying Health Care," p. 5.

81 Leigh Page, "New approach to long-term care for elderly: states integrate Medicare, Medicaid coverage," *American Medical News*, vol. 39, no. 30, August 12, 1996, p. 3.

82 *Ibid.*

Medicaid caseload. To achieve significant savings in Medicaid over the long run, something must be done either to reduce the cost or the number of disabled and elderly recipients.

Second, enrolling AFDC recipients and other poor persons in Medicaid managed care doesn't resolve the basic question of whether these individuals need medical care more than other forms of public assistance. There is no incentive for the recipient to consume less health care—though there is an incentive for the managed care network to provide fewer services—in order to use scarce resources to get off the dole. For these recipients, the managed care solution fails to address the extent to which Medicaid is a welfare program rather than a health care program.

I recently corresponded with the head of a successful managed care company enrolling almost 1,000,000 individuals in North and South Carolina. He summarized the relationship between managed care and Medicaid this way:

> *Managed care can indeed reduce to some degree the cost of medical services. However, the real problem which no one wants to address is this: Medicaid is the most comprehensive health care program available to anyone. There are virtually no limits, essentially all costs are fully paid, with the exception of small copayments. . . The problem few politicians wish to address is that eligibility growth, more than medical inflation, is probably the major factor causing the program costs to soar. Unless the political issues affecting Medicaid are honestly addressed, placing Medicaid under managed care, while helpful, of course, will not solve the problem of soaring costs.*[83]

[83] Letter to author, Otto Mueller, MedCost, Winston-Salem, North Carolina, July 1, 1996.

Part 6

A Strategy to "Divide and Reform"

A key element of a successful Medicaid reform strategy is recognizing that Medicaid is not a program but a set of programs, with different goals and different problems. Dividing Medicaid into its constituent parts, and then using the appropriate policy to address each part's unique problems, is the first step to getting control of this largest state-run entitlement program and reducing its costs to taxpayers. Here is a 10-point plan for how a state might go about this.

A. Poor Children and Adults

1. Continue To Reform Welfare

The Personal Responsibility and Work Opportunity Reconciliation Act, passed by Congress and signed by the President in 1996, makes substantial changes in such programs as AFDC, SSI, child support enforcement, immigration, child care, food stamps, and social services. Even before its passage, however, a number of states—among them Wisconsin, Michigan, Oregon, Massachusetts, and California—had long been reforming their state welfare programs to encourage work and personal responsibility. In just the past two years, many other states have joined in with work requirements, time limits, and other measures.

Apart from the impact on AFDC and other cash programs, welfare reform has tremendous implications for Medicaid. The most obvious is on eligibility. If states can successfully move people off the AFDC rolls, then at least some will no longer qualify for Medicaid. There is some evidence that this is happening already. In November 1996, the National Governors' Association reported that state finances were doing better than expected, largely due to a slowdown in the growth of Medicaid. While managed care may be one factor (again, most analysts agree that it at least cuts costs in the short term) another is declining caseloads for AFDC caused by a combination of state reforms and economic growth.[84]

Other than this indirect effect, however, Medicaid has not yet been folded into the general discussion of welfare reform. Congress purposefully left Medicaid at of the 1996 welfare bill in a compromise with President Clinton. The bill does not change the entitlement nature of Medicaid, nor does it apply the standards expected of welfare recipients to medical assistance.[85] States have also treated Medicaid as an issue separate from welfare reform, partly out of conviction and partly because of federal regulations.

2. Institute Vouchers For Non-Disabled, Non-Elderly Recipients.

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[84] Robert Pear, "States reporting financial surpluses," *The News & Observer*, November 14, 1996, p. 4A.

[85] Judy Waxman and Joan Alker, "The Impact of Federal Welfare Reform on Medicaid," Families USA, Washington, D.C., August 19, 1996, p. 1.

Families who become eligible for AFDC or otherwise meet income thresholds as determined by states should receive vouchers for 1) the purchase of private health insurance, 2) enrollment in managed care either through a state purchasing pool or some other means, or 3) deposit in medical or other savings accounts. These vouchers should be distributed on a six-month basis to reduce administrative burden and facilitate long-range planning. They should be fixed in value, perhaps subject to some adjustment for age, gender, and county of residence. The amount of the voucher could be set according to the average cost of private health plans in the region or to current costs for the AFDC portion of the Medicaid program, subsequently increased by a measure of medical inflation.

A key element of a successful Medicaid reform strategy is recognizing that Medicaid is not a program but a set of programs, with different goals and different problems.

Regardless of the size of the voucher, it should be considered part of the welfare package available to state recipients. Therefore, all requirements imposed for receiving benefits such as AFDC and food stamps—time limits, work requirements, school attendance, etc.—should apply to medical vouchers. Furthermore, welfare recipients of medical assistance should have the option of depositing any part of the voucher not spent on medical insurance or care not only into medical savings accounts but also in *educational savings accounts*, from which they could make withdrawals for theirs or their children's education, or *individual development accounts*, from which they could make withdrawals for housing, transportation, or other approved expenditures to help get themselves of public assistance. Obviously, the same goal might be realized by the creation of "Super IRAs," as proposed by some members of Congress, in which tax-deductible deposit limits to IRAs would be raised and withdrawals without penalty would be expanded to include medical, educational, or first-home expenses.

It is crucially important that welfare families be able to use public assistance dollars to meet their most immediate needs. Otherwise, state and federal tax money will continue to be squandered for services that low-income recipients don't actually need and that don't help them become self-sufficient.

Vouchers combined with savings accounts will let recipient families choose the health coverage that best fits their needs. By allowing choices rather than dictates, vouchers have the promise of better quality care for recipients while at the same time allowing the state to control expenditures not only by setting the value of the voucher but also by giving recipients a financial incentive to shop wisely for care.[86]

Medical Savings Accounts. An extensive argument in favor of medical savings accounts is beyond the scope of this paper and can in any event be found in great detail elsewhere.[87] For the purposes of this discussion, it need only be mentioned that studies of patient behavior show that the prospect of saving money rather than spending it on health care reduces consumption of medical services but not to a degree that would keep patients from getting necessary preventive care.[88] An analysis of the potential Medicaid savings from

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86 Barry W. Poulson, "Health Vouchers Could Cure the Medicaid Crisis," *Independence Issue Paper No. 1-93*, January 13, 1993.

87 The best treatment of MSAs is probably John Goodman and Gerald Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington: The Cato Institute, 1992).

88 Michael Tanner, "Why Medisave Accounts Make Sense," *Consumers' Research*, August 1995, pp. 20–21.

medical savings accounts by Milliman & Robertson Inc. estimated that spending on medical services could be 14 percent lower.[89]

Of course, the cost savings or other benefits from Medicaid MSAs, like those of long-term use of managed care or other reforms, are mostly speculative. A number of states have considered MSAs for Medicaid. Texas has enacted a pilot project to use MSAs for a limited number of Medicaid recipients, while in 1994 the Indiana Senate (but not the House) enacted a plan to refund a portion of unspent Medicaid funds to recipients for use in day care or job training.[90] These kinds of experiments must go forward before strong conclusions can be drawn.

On the quality implications of encouraging consumer choice among Medicaid recipients, we do have some information, however. Several states such as Massachusetts and Michigan have established "consumer-directed" models of providing Medicaid services, particularly for the elderly or disabled. Surveys have found that client satisfaction is higher when they control personal care services rather than having those administered by third parties, and costs are often lower.

Vouchers combined with savings accounts will let recipient families choose the health coverage that best fits their needs. By allowing choices rather than dictates, vouchers have the promise of better quality care for recipients while at the same time allowing the state to control expenditures.

In Michigan, Medicaid reformers might learn something from the use of two-party checks to pay attendants (often family members rather than strangers) for attendant care. Requiring the patient to co-sign the paycheck of the personal care attendant makes it clear that the latter works at least partly for the former, rather than for the state, and creates incentives for providing satisfactory service. It also seems to reduce per-client costs.[91]

For states to convert Medicaid dollars into vouchers for poor families is not much different from their current experimentation with capitated managed care, which after all involves determining appropriate per-capita expenditures (through a combination of actuarial research and competitive bidding). States will probably want to retain a role in organizing pools of Medicaid recipients and soliciting bids and information from managed care companies, much as states and the federal government provide "bulk buying" power to government employees who choose among alternative health plans.[92] The difference is that, with a voucher rather than automatic enrollment, Medicaid recipients could access another purchasing pool or purchase plans or care directly, creating additional competition and expanding choice.

A voucher might also make it easier for recipients to retain coverage after leaving the welfare rolls, because they (or their new employers) could simply substitute premiums for what the voucher had been paying. Since

89 Mark E. Litow, "The Potential of MSAs with Medicaid," Milliman & Robertson, Inc., July 18, 1995, p. 6.

90 James R. Cantwell, "Reforming Medicaid," *Policy Report No. 197*, National Center for Policy Analysis, August 1995, p. 8.

91 Pamela Doty, Judith Kasper and Simi Litvak, "Consumer-directed models of personal care: lessons from Medicaid," *The Milbank Quarterly*, Fall 1996, p. 377.

92 See discussion of this proposal in David Dunn, "Medicaid Vouchers: An Idea Who Time Has Come," Report, Resource Institute of Oklahoma, Oklahoma City, June 1993, pp. 7–8.

states would set eligibility criteria, they might decide that rather than providing "all or nothing" vouchers—in which a household would receive the whole voucher amount if below the income threshold and nothing if above the threshold—to instead provide vouchers of declining value based on recipient income or assets.[93]

Indeed, states might elect, as Arizona has done, to invite private employers or individuals to buy coverage through the state-operated purchasing pool, so that the difference between a Medicaid recipient, a state employee, and a privately insured individual in the pool or chosen health plan would simply be the source of funding to pay the premiums.[94] States would want to make sure that any such pool they operate contain at least one, and preferably several, MSA plans in addition to traditional indemnity plans and managed care. As an intermediate step to including MSAs, states might simply experiment with gain-sharing measures to reward Medicaid recipients who keep medical consumption below a certain level with "cash back." Private-sector employers have had some success with this approach.[95]

The most important argument for vouchers, however, is that they lend themselves more easily to being treated as welfare benefits such as AFDC and food stamps. They can be withheld or docked due to noncompliance with state rules, including work requirements and time limits. This would make medical assistance for the poor a temporary and reciprocal relationship, as public assistance should be, rather than an open-ended entitlement.

B. The Near-Poor Uninsured

In recent years, state have expanded Medicaid to cover children and pregnant women above the poverty line and ineligible for cash welfare programs. In addition, some states—most notably Tennessee—have used the projected Medicaid savings from compulsory managed care to fund expansion of the program to cover uninsured families well above the poverty line.[96] The stated goal of these expansions has been to reduce the number of uninsured families, particularly children, and to reduce overall health care expenditures by guaranteeing preventive care to children and pregnant women.

But it is not at all clear that Medicaid coverage is the appropriate response to either need. Like the pros and cons of MSAs, a full discussion of the problem of the uninsured is beyond the scope of this paper and detailed elsewhere.[97]
But keep in mind these points:

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93 A similar proposal for replacing Medicaid with a sliding-scale of health insurance subsidies is discussed in Lou Rossiter, "Bridging the Gap: Health Care Coverage for Low-Income Families," House Wednesday Group, Congress of the United States, March 30, 1992.

94 There is some danger in moving in this direction. First, expanding a Medicaid purchasing pool to allow employers or individuals to participate by spending private dollars could create pressures to subsidize some of these buyers. Also, if the purchasing pool enjoyed state-granted advantages, it could compete unfairly with existing HMOs and insurance plans.

95 "Answering the Critics of Medical Savings Accounts: Part I," *Brief Analysis No. 132*, National Center for Policy Analysis, September 16, 1994, p. 1.

96 Terree P. Wasley, "TennCare: Health Care Reform Dream or Disappointment?" *State Backgrounder No. 1021/S*, The Heritage Foundation, Washington, D.C., February 28, 1995. Also, the state of Kentucky has included a provision in its new Medicaid managed care plan that all savings must be placed in an indigent-care trust fund and used to expand Medicaid eligibility and services, rather than being returned to taxpayers. "Kentucky moving ahead with Medicaid realignment," *Modern Healthcare*, September 23, 1996.

97 For discussions of the issues surrounding the uninsured population, see Timothy D. McBride, "Estimating the Real Number of Chronically Uninsured," *Journal of American Health Policy*, July-August 1994, pp. 16–23; "Dissecting the Uninsured" (editorial), *The Wall Street Journal*, April 15, 1993, p. 18A; and Joseph L. Bast, Richard C. Rue & Stuart A. Wesbury, Jr., *Why We Spend Too Much On Health Care* (Chicago: The Heartland Institute, 1992), pp. 68–92.

1. The uninsured population is a diverse group.

Some, but not many, are uninsured because of preexisting conditions that make their insurance premiums unaffordable. Some are uninsured because they choose not to enroll, either paying for services out-of-pocket, foregoing some care, or receiving uncompensated "free" care from hospitals and physicians. Some uninsured persons or families do not view the health plans in their area as being worth their price. (A third of uninsured households earn more than $30,000 a year and 10 percent earn more than $50,000.)

A voucher might also make it easier for recipients to retain coverage after leaving the welfare rolls, because they (or their new employers) could simply substitute premiums for what the voucher had been paying.

2. Free" care provided to the uninsured is at least partially offset by the taxes the uninsured pay.

Medical cost shifting occurs when one group of patients pays less than their true cost of medical care. The extent of cost shifting is a subject of great debate, but even at the high end represents only about 3 percent of the nation's annual health care bill. By comparison, bad debts for business in general is about 2.4 percent of sales.[98] Since cost-shifting is essentially the medical version of "eating" uncollectable debts, this comparison shows that it is no more of a problem in health care than in other businesses.

More importantly, because the uninsured do not receive the tax benefits received by those who have employer-provided health insurance, they in effect pay for a substantial amount of the "free" care they receive. The value of exempting health insurance from federal and state income taxes and payroll taxes is as much as half the cost of the health insurance itself. But the full benefits of this tax exemption do not accrue to self-employed individuals or those working for small firms that do not offer health insurance as a benefit. Faced with the prospect of buying health coverage with after-tax dollars, many choose not to do so. A 1994 analysis by the National Center for Policy Analysis found that the uninsured paid about $19 billion in additional taxes, compared with their insured counterparts, while receiving about $28 billion in "free" care. NCPA suggests that the extra tax money be returned to hospitals and clinics to help compensate for lost income.[99]

In other words, the evidence shows that many of the near-poor uninsured households who receive Medicaid coverage today are already paying for this coverage, through higher taxes on their incomes than paid by those insured by firms. Rather than being incapable of purchasing health care, including preventative services, these households might well be able to purchase their own care if tax changes allowed them to do so efficiently.

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98 "Are the Uninsured Freeloaders?" *Brief Analysis No. 120*, NCPA, August 10, 1994, p. 1.

99 *Ibid*., p. 2.

3. Expanding Medicaid to cover the uninsured is unlikely to save taxpayer money in the end.

If the uninsured receive health insurance, especially when it is partially or fully subsidized by the government, they will consume more health services rather than fewer. This is not only common sense but is buttressed by studies. The Congressional Budget Office, for example, estimates that the uninsured's use of hospital services would increase by almost 30 percent and their use of physician services would almost double.[100]

In the Medicaid context, this argument is most often heard regarding children and pregnant women: unless they are insured and receive preventive care services, untreated problems will mushroom into serious and costly conditions. Furthermore, the argument goes, because many of these patients will end up in emergency rooms anyway, taxpayers will pay one way or the other.

If the uninsured receive health insurance, especially when it is partially or fully subsidized by the government, they will consume more health services rather than fewer.

The available evidence doesn't support this position. For one thing, simply bringing children and mothers into Medicaid doesn't guarantee that they will use preventive services—though they may well make greater use of physicians and other providers for acute conditions. Even vigorous outreach programs such as direct mail, phone calls, and home visitation by nurses don't seem to make much difference in preventive service consumption. One study of Medicaid-eligible families in North Carolina found the results of these outreach programs to be statistically significant but small.[101] Another study for the U.S. Agency for Health Care Policy and Research found that for low-income preschool children without health insurance, a full year of Medicaid increase the probability of bringing children in for routine check-ups by only 17 percent. "Factors other than insurance and income, such as the lower educational attainment of low-income mothers, explain approximately 80 percent of the gap between low-income and other children in their well-child visits," the study concluded.[102]

Comparing the costs and benefits of providing prenatal care through government programs, University of Washington researchers concluded that there is no evidence such care pays for itself by heading off future health care costs. They found that the research on which such claims are based is full of methodological problems. "The current perception of prenatal care oversimplifies the difficulties of delivering prenatal care to women who do not now receive it, overestimates the benefits of prenatal care, and contributes to the medicalization of complex social problems," they wrote.[103] Indeed, there is no clear evidence that infant mortality rates, for example, bear any relationship to Medicaid coverage or prenatal care.[104] Similarly, there are many public and private efforts to immunize children other than Medicaid, and no evidence that

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100 "Is Universal Coverage Necessary to Control Health Care Costs?" *Brief Analysis No. 119*, NCPA, August 5, 1994.

101 Maija Selby-Harrington, James R. Sorenson, Dana Quade, et al. "Increasing Medicaid child health screenings: The effectiveness of mailed pamphlets, phone calls, and home visits," *American Journal of Public Health*, vol. 85, no. 10, October 1995, pp. 1412–1417.

102 "Low-Income Children: The Effect of Expanding Medicaid on Well-Child Visits," Intramural Research, National Medical Expenditure Survey, Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, 1994.

103 Jane Huntington and Frederick A. Connell, "For Every Dollar Spent—The Cost-Savings Argument for Prenatal Care."

104 "Infant Health" (editorial), *The Wall Street Journal*, November 1, 1991.

Medicaid coverage will change immunization rates significantly.[105] Overall, a 1996 national study of Medicaid managed care found that children had about 60 percent more hospital days annually than uninsured children with the same characteristics, suggesting that insuring children doesn't, in the end, reduce their consumption of hospital care and may well increase it substantially.[106]

Comparing the costs and benefits of providing prenatal care through government programs, University of Washington researchers concluded that there is no evidence such care pays for itself by heading off future health care costs.

This is not to say, of course, that preventive care isn't worthwhile or that children and pregnant women don't benefit from it. But it doesn't appear to pay for itself in future savings. At its root, the argument for expanding Medicaid coverage to able-bodied persons above the poverty line is a moral one, and can be answered with a moral one—health care insurance is not a right but a service available for purchase, and a limited government has no business promising free health care to able-bodied persons who aren't poor by conventional definitions. Thus:

1. Resist expansion of the Medicaid program to able-bodied persons above the poverty line, and attempt where possible to roll back previous expansions.

Due to political considerations, federal and state decisions to expand Medicaid coverage to non-poor women and children may be extremely difficult to change, particularly in the short-term. One approach might be to introduce a sliding-scale systems of premiums for all able-bodied Medicaid recipients above the poverty line, so they are at least partially paying for the medical services they receive. Another approach would be to treat Medicaid coverage for the non-poor (which will be temporary in any event, as per the time limit recommended above) as a loan rather than a grant. The dollar value of vouchers paid to these recipients would have to be repaid over a period of years.

2. Enact Reforms At The State Level To Reduce The Cost Of Health Insurance And Thus The Ranks Of The Uninsured.

Such reforms include repeal of state mandates on insurance benefits, reform of occupational licensing laws, and changes in the tax treatment of employer-provided health benefits. On that last point, the ability of states to make headway in equalizing the tax treatment of health benefits is obviously limited by the fact that the federal tax burden is much more substantial than the state tax burden. Providing 100 percent state tax deductibility for health insurance premiums or medical savings account deposits by individuals may help a little, but the federal tax liability is far larger.[107]

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[105] Merrill Matthews and John C. Goodman, "Myths About Our Health Care System: Lessons for Policy Makers," Policy Backgrounder No. 136, NCPA, May 11, 1995, pp. 8–10.

[106] M. Susan Marquis and Stephen H. Long, "Reconsidering the effects of Medicaid on health care service use," *Health Services Research*, Vol. 30, No. 6, February 1996, p. 791.

[107] Furthermore, the federal deductibility for state taxes paid would reduce the value of the state tax deduction, because households formerly paying state taxes on health expenditures—and deducting those taxes from their federal taxable income—would now be paying less state taxes, thus reducing to some degree their federal deduction.

C. The Disabled

Converting the disabled and mentally ill portions of Medicaid into a voucher program poses challenges not present for poor families. The biggest one is eligibility. Many disabled Medicaid recipients access the system via SSI, a program rife with waste and fraud. The incentive to manufacture or exaggerate disabilities, particularly mild mental illnesses, in order to qualify for government services is very real.[108] Vouchers might make this problem even worse, particularly if recipients could use unspent dollars for other purposes.[109] So this population merits a different approach.

The reason for tightening the requirements was that the IFA, in particular, allowed parents to coach children to fake or exaggerate psychological conditions that, taken together, could qualify them for monthly cash payments.

1. Continue to Reform Disability Programs.

The federal reform bill of 1996 has its greatest impact on SSI, which will then affect Medicaid outlays. Legal immigrants, for example, are now ineligible for SSI. States can decide whether to continue Medicaid coverage for these immigrants (with some exceptions) and should use this authority to stop subsidizing the health care of non-citizens. States can also bar future immigrants from Medicaid and other means-tested assistance for five years (again with a few exceptions) and afterwards would qualify only if they *and* their "sponsors" together have income and assets below the threshold—not a likely scenario.[110]

The bill also tightened childhood eligibility for SSI, a long-overdue reform. The CBO estimates that about 15 percent (47,000) of the children losing eligibility for SSI will lose Medicaid coverage as well (the others will remain by qualifying through AFDC or the near-poor children routes).[111] This is a large number, but does not represent the prospect of dumping seriously ill or disabled children out on the street. Instead, it represents an attempt to target childhood SSI, and thus Medicaid, coverage to those children who actually suffer from demonstrable and debilitating conditions.

The childhood disability SSI program is often misunderstood and deserves a bit more explanation here, because of its role as one route to Medicaid eligibility. In FY 1995, the families of nearly 1 million American children received SSI subsidies of up to $470 a month. As SSI recipients, they are automatically eligible for Medicaid in most states (this requirement is not a federal mandate). Children with mental retardation were the largest single group of recipients (42 percent) followed by those with physical disabilities (33 percent) and mental disorders (25 percent). Importantly, the SSI program is not the source of income replacement for children who have lost a parent; those benefits are paid out of the Social Security trust fund.[112]

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[108] Heather MacDonald, "SSI Fosters Disabling Dependency," *The Wall Street Journal*, January 20, 1995, p. A18.

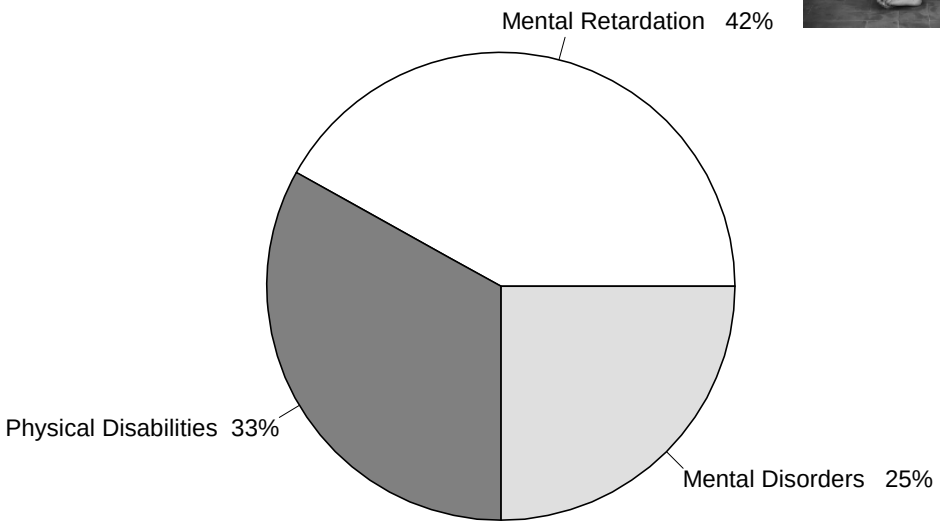
[109] John Hall and William D. Eggers, "Health and Social Services in the Post-Welfare State: Are Vouchers the Answer?" Policy Study No. 192, Reason Foundation, August 1995.

[110] Waxman and Alker, "The Impact of Federal Welfare Reform on Medicaid," p. 2.

[111] "The Impact of Children's SSI Program Changes in Welfare Reform," Bazelon Center for Mental Health Law, Washington, D.C., August 7, 1996.

[112] "The Children's SSI Program," Bazelton Center for Mental Health Law, Home Page, updated August 7, 1996.

Figure 8: Type of Disability for Recipients of the Childhood Disability SSI Program



Before the 1996 welfare reform bill, children had two ways of qualifying for SSI disability benefits: 1) exhibiting any condition on a list of medical impairments that constitute automatic eligibility, or 2) determination by the Social Security Administration through an Individual Functional Assessment (IFA) that a child's medical condition affects his or her ability to function. Importantly, the IFA allowed a child to qualify for SSI even if he or she didn't exhibit any conditions listed by the statute, substituting the notion that a combination of less serious conditions could approximate the same level of disability. This standard was, in fact, the result of a 1990 U.S. Supreme Court decision.[113]

The reform bill eliminated the IFA path to eligibility, and substituted a more restrictive definition of the first method: a child must have "a medically determinable physical or mental impairment which results in marked and severe functional limitations" of substantial duration. The reason for tightening the requirements was that the IFA, in particular, allowed parents to coach children to fake or exaggerate psychological conditions that, taken together, could qualify them for monthly cash payments. After the 1990 court decision ordering IFAs, the Social Security Administration issued rules defining certain "age-inappropriate behavior" in children—such as extreme shyness or public disruptiveness—as indicative of a disabling impairment. The administration also created an outreach program to recruit children onto the rolls. In less than four years, the children's SSI caseload more than doubled.[114]

Instituting careful eligibility guidelines for public assistance programs is a crucial government responsibility, if for no other reason because careful guidelines preserve the programs for those who truly need them. Even liberal critics of the 1996 welfare reform bill admit that the largest group of children likely to be affected by tightening SSI eligibility are those with "mood disorders." These children may well require medical attention or other aid; the question before Congress was whether their families should be given cash subsidies and free medical care, as well. Lawmakers answered that question in the negative.

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[113] *Ibid.*

[114] Randy Fitzgerald, "America's Shocking Disability Scam," *Reader's Digest*, August 1994, pp. 103–104.

2. Tighten State Eligibility Standards for Disability.

Even after its 1996 reforms, SSI remains a troublesome program from the standpoint of controlling entitlement spending, targeting public assistance to the truly needy, and matching needs with appropriate aid. For example, it is not clear why children should receive benefits from a disability program intended to replace lost income from not being able to work. Perhaps a different program, designed for children rather than adults and focusing more on services rather than cash, would better meet their needs. Nor do SSI standards truly distinguish those who can work from those who can't.[115]

States should exercise control over who qualifies for Medicaid through a disability, rather than putting eligibility at least partly on the SSI "autopilot." Moreover, rather than using categorical and medical needs to make an "all or nothing" judgment about whether an individual is eligible, states should construct a sliding-scale of subsidies, based on medical condition and ability to work, and charge premiums to recipients based on their ability to work, as well as family resources.

Instituting careful eligibility guidelines for public assistance programs is a crucial government responsibility, if for no other reason because careful guidelines preserve the programs for those who truly need them.

Arizona's experience with ALTCS might be instructive here. The program conducts Pre-Admission Screening to determine whether an applicant needs or is significantly at risk of needing institutional care. As noted earlier, this screening process, not competitive contracting itself, may well account for most of the cost savings for which ALTCS is known.

3. Use Competition Where Possible to Deliver Services More Efficiently

Most Medicaid managed care experiments have yet to include the disabled population. This is unfortunate since mandatory managed care and competitive contracting is better suited to this population than to the AFDC population, for which health care needs are often outweighed by other needs. For the disabled, particularly those "wards of the state" whose conditions make them unable to work and costly to treat, the key issue for states will be how best to deliver the medical and custodial care the public will expect government to pay for.

Based on Arizona's experience and that of a few other jurisdictions, states should keep several considerations in mind. First, states must decide whether to award more than one contract per county or other local jurisdiction (as is typically done in managed care for AFDC recipients). While consumer choice is often desirable, multiple contractors create an "adverse selection" problem in that HMOs would have incentives to discourage, at least subtilely, enrollment by the most seriously disabled patients in the area. By awarding only one contract per county, as Arizona does, the state can make sure that HMOs cannot game the system and must serve expensive cases as well as less expensive ones.

A related issue is whether to "carve out" segments of the disabled population—such as the mentally ill, substance abusers, or those with other specific diseases or conditions—for separate contracts or to include patients with varying needs under one contract. States now using contractors for some disabled recipients have often opted for

[115] Wright, pp. 18–19.

carve-outs, though Arizona discourages the practice. With carve-outs, one might encourage providers with specific expertise to bid that would otherwise not be interested. On the other hand, a unified bidding process would assist in coordinating care for those with multiple problems and would work to further prevent adverse selection problems.[116]

As noted earlier, there would appear to be significant savings available by shifting some nursing home residents into smaller group homes or into residential care by family or friends. ALTCS uses rigorous evaluation and capitation rates to encourage contractors to place people in home care if possible. However, unless states devise and enforce strict eligibility guidelines, making home-based care more widely available could have the effect of raising rather than lowering overall costs. The Urban Institute's Wiener explains that patients' aversion to nursing home explains this paradox. Given a choice between nursing home care and no formal services, many will choose the latter. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset relatively small reductions in nursing home use.[117]

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D. The Elderly

It is in some ways entirely accidental that Medicaid has become a middle-class entitlement for many families with aged parents in nursing homes. For reasons explained previously, there is a significant difference between the disabled Medicaid population and the elderly (and disabled) Medicaid population—qualitative, in the sense that disability becomes increasingly likely and predictable as one ages, and quantitative, in the sense that the number of disabled persons is likely to remain relatively low and decline as a percentage of the population, while the number of elderly persons needing long-term care will grow both in absolutely terms and as a share of the population. An entitlement to long-term care for the elderly is, in other words, neither morally nor actuarially equivalent to a governmental promise of care to disabled children and young or middle-aged adults.

It would be unfair and counterproductive, however, for states and the federal government to attempt to end this entitlement overnight. Instead, political leaders should take immediate steps to control the cost of long-term care for the elderly, using the same model discussed above for the non-elderly disabled plus more vigorous enforcement of eligibility standards and asset-recovery requirements.

At the same time, government must encourage individuals and families to make plans to cover their own long-term care needs. They will not do so until 1) political leaders honestly state the long-run insolvency of the Medicaid program and 2) changes in the tax code are made to allow families to plan effectively for the future through insurance or medical savings accounts funded by before-tax dollars.

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[116] "Applying the Lessons of Arizona's Medicaid Managed Care Program," The Henry J. Kaiser Family Foundation and The Flinn Foundation of Arizona, Conference Report, December 2, 1995, p. 5.

[117] Wiener, "Can Medicaid Long-Term Care Expenditures," p. 5.

1. Enforce Asset-Transfer, Asset-Recovery, And Spousal Support Requirements.

The Omnibus Budget Reconciliation Act of 1993 requires each state to look back three years when determining eligibility for long-term care services to see if a Medicaid recipient has transferred money or other assets to other persons, such as their children. Furthermore, when a Medicaid recipient dies, the state is expected to recover some of the past cost of providing long-term care.[118] The Kassebaum-Kennedy law passed in 1996 extended the look-back period to five years and instituted criminal penalties for violations.[119]

An entire industry of lawyers, accountants, and authors has grown up around the loopholes in asset-transfer and asset-recovery laws.[120] One popular book, *Avoiding the Medicaid Trap*, counsels that some people may be able to simply refuse to pay the nursing home bills of their spouses, effectively shifting the burden to taxpayers even though spouses are legally required to pay such bills. "The experience of many states is that state Medicaid agencies are lax or don't have the staff to pursue support rights," the book states. "In many cases the spouse-at-home has been able to protect his or her savings using this technique." The book also suggests divorce as an option for shielding assets from the government.[121]

Government must encourage individuals and families to make plans to cover their own long-term care needs.

States are, indeed, lax. The federal government has been legislating against asset transfers and other evasion techniques for more than a decade, but states routinely fail to enforce their provisions and don't recover much in the way of assets after a Medicaid patient's death. For 1993, the amount recovered from the estates of deceased beneficiaries averaged only about one percent of Medicaid nursing home expenditures for the top 10 states, an extremely small percentage.[122] The problem isn't just that states don't try—but because trying is politically unpopular, this is part of the explanation. Families retain lawyers and accountants, gain an understanding of the rules and regulations, and move assets early enough to avoid recovery.

States should improve enforcement of these provisions. The tougher sanctions in the 1996 Kassebaum-Kennedy law ought to help.[123] Ultimately, however, families will continue to evade them—mostly successfully—because they have come to view nursing home care as a government-provided entitlement. If families were faced with most or all of the cost of nursing home care for the elderly, it is likely that less nursing home care would be demanded. During the 1960s, so-called "family responsibility requirements" to held shoulder some of the financial burden of aid for the elderly, enacted in 35 states under the Old Age Assistance program, resulted in many elderly patients choosing not to apply for assistance rather than force

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[118] Cantwell, "Reforming Medicaid," p. 9.

[119] Magnusson, "Medicaid Is Getting Tough With Granny," p. 145.

[120] See Phillip Longman, "Pretend paupers: Florida's Medicaid program is turning into a middle-class and well-to-do inheritance protection scheme," *Florida Trend*, December 1995, p. 40.

[121] Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Cost of Nursing-Home Care*, 3rd Edition, New York: Henry Holt and Company, 1995, p. 93.

[122] Wiener, "Can Medicaid Long-Term Care Expenditures," p. 4.

[123] A promising sign is that the National Association of Elder Law Attorneys is up in arms about the new law, saying it will have a "chilling effect" on asset transfers. See Richard Keil, "Health law hits elderly in the home," *The Charlotte Observer* (Associated Press), December 7, 1996, p. 1A.

their children to pay part of the cost of their care. Idaho instituted a family responsibility requirement in the early 1980s and saw applications for Medicaid nursing home care drop eight percent.[124]

The federal government has been legislating against asset transfers and other evasion techniques for more than a decade, but states routinely fail to enforce their provisions and don't recover much in the way of assets after a Medicaid patient's death.

2. Set a date certain after which elderly recipients or their families must pay for their own long-term care expenses.

As a practical matter, it may be impossible, both administratively and politically, to improve much on current asset-transfer and asset-recovery programs. A more straightforward approach to be to make it clear that the entitlement to Medicaid for the elderly will cease at some point in the future, perhaps 15 or 20 years. Much like today's Social Security and Medicare programs provide full coverage starting at age 65, so Medicaid coverage could end at age 65. For those who develop a need for long-term care after reaching the age of 65, a combination of savings, insurance, and family resources would pay the bill.

The need for a gradual transition to family responsibility for long-term care was clearly identified during the 1995 Congressional debate on Medicaid. Republicans reformers originally included a provision to allow states not only to target the assets of elderly Medicaid recipients but also the assets of their adult children whose incomes were above the state median. This proposal generated a firestorm of protest, and was shelved when Medicaid reform was largely divorced from the final welfare reform bill of 1996.[125] By setting a date and giving families time to plan for the future, political leaders could dramatically change the way the public views Medicaid while providing a lengthy period of transition during which families could make provisions for the future.

The policy would be similar to previous Congressional actions to raise age limits for Social Security gradually and with substantial warning time. The two ideas have similar purposes, after all: bringing promises of government entitlement into line with demographic and financial reality. Furthermore, just as it would make no sense for the government to guarantee persons below retirement age a Social Security pension, it makes no sense to guarantee an elderly person with a lifetime to save and prepare an entitlement to free nursing home care. For those who don't prepare, who have no family to support them, and are otherwise completely helpless, an array of voluntary programs and charitable institutions, perhaps supplemented by local government agencies, should serve as an adequate safety net.[126]

3. End disincentives to save and to purchase long-term care insurance.

[124] Wiener, "Can Medicaid Long-Term Care Expenditures ," p. 7.

[125] Christopher Georges and Dana Milbank, "Clinton Attacks GOP Plan for Medicaid, Affecting Nursing-Home Residents' Kin," *The Wall Street Journal*, December 11, 1995, p. A2.

[126] Charity care for the poor and elderly is discussed at length in Malcolm Gladwell, "Doctors Without Bills," *Reason*, March 1992, pp. 40–43.

The Kassebaum-Kennedy bill made a change in federal tax law that may affect the elderly and Medicaid. Both premiums for private long-term care insurance and out-of-pocket payments made for long-term care can now be added to the "medical expenses" deduction on federal income taxes (which is deductible as long as it exceeds 7.5 percent of adjusted gross income).[127] This doesn't go nearly far enough. Washington and the states should treat premiums for long-term care insurance exactly the same for tax purposes as they do medical insurance—and indeed expanding tax deductibility so that individuals as well as firms can write off 100 percent of premiums paid. Also, when long-term care is paid for either through savings or insurance benefits, it should never be considered income for tax purposes, regardless of adjusted gross income.

Washington and the states should treat premiums for long-term care insurance exactly the same for tax purposes as they do medical insurance—and indeed expanding tax deductibility so that individuals as well as firms can write off 100 percent of premiums paid.

Currently, only about 4 to 5 percent of the elderly have any type of private long-term care insurance. Most wait too long, are disadvantaged by poor tax policy, or simply put their faith in Medicaid (or, wrongly, Medicare) to pay the bills. But getting control of Medicaid expenditures means encouraging people to either purchase long-term care insurance or accumulate medical savings (or, most likely, a combination of both). The long-term insurance industry is young but growing. In 1987, only 800,000 policies were sold. But more than 2.4 million were sold in 1991. The market has doubled again since then, and will receive another boost from the new law.[128] The American Health Care Association calculates that, if the majority of persons over age 55 were covered by long-term care insurance, the percentage of persons in nursing homes paid for by Medicaid would fall from the current 67 percent to 25 percent within 25 years.[129]

Medical savings accounts, if started even in middle age, could build significant tax-deferred value before most individuals face significant long-term care expenses. Saving has one major advantage over insurance. Since more than half of the elderly will never set foot in a nursing home, and many more for only a few months, many insurance subscribers will make few or no claims, and thus receive no benefits (other than peace of mind) for the premiums paid. But the elderly's medical savings, if not used for long-term care, can be left to heirs.

E. The Role of Washington

These recommendations would depend to a large extent on the willingness of the federal government to change Medicaid law and regulations, especially for the non-poor families and the elderly. The best solution would be for Washington to devolve Medicaid entirely to the states, or at least to convert Medicaid dollars into block grants (a proposal discussed at length elsewhere).[130] The administration and Congress would have

[127] Quinn, "Long-Term Care Insurance Looking Better."

[128] Merline, "Making Money By Denying Health Care," p. 11.

[129] Health Care Task Force, "Private Long-Term Care Insurance: The Solution for the States," *The State Factor*, American Legislative Exchange Council, vol. 18, no. 7, July 1992, p. 4.

[130] See Cantwell. Also see John C. Liu, "Key Changes Needed in the Governors' Medicaid Proposal," *F.Y.I. No. 89*, The Heritage Foundation, March 12, 1996.

to allow significant state experimentation, because many of the cost and benefit implications of reforms such as managed care or vouchers remain unclear and will simply have to be tested through experience.

The American Health Care Association calculates that, if the majority of persons over age 55 were covered by long-term care insurance, the percentage of persons in nursing homes paid for by Medicaid would fall from the current 67 percent to 25 percent within 25 years.

Still, states already have the power to implement some of these recommendations, including having some leeway on eligibility requirements and benefits, using competitive contracting to deliver services, implementating welfare reforms, and enforcing asset-recovery provisions.

Part 7

Conclusion

When politicians and policy analysts talk about the problem of entitlements, they are usually referring to Social Security, Medicare, and welfare programs in the context of a burgeoning federal debt. But for states, Medicaid is the entitlement program that poses the greatest threat to other state services and to family budgets. Since 1965, the percentage of the median two-income family's income devoted to taxes grew from 29.3 percent to 38.4 percent. It is no coincidence that the bulk of this growth in the tax burden is due to increases in payroll taxes (funding Social Security and Medicare) and state/local taxes, which have become increasingly devoted to Medicaid.[131] Getting control of entitlements is necessary in order to reverse this growth in the tax burden and focus scarce resources on delivering core governmental services.

Medicaid reform is, admittedly, underway. As most states experiment with managed care, we will be able to gauge more accurately its likely affects on the cost and quality of care. Similarly, changes in tax laws and Medicaid regulations will give us some insight into the demand for long-term care insurance and the likelihood of deterring Medicaid fraud. But it is important to remember that reforming Medicaid is not simply an accounting problem. The core problem cannot be wished away with competitive contracting or the closing of loopholes. Politicians and the voters will have to grapple with the basic issue of to what extent medical care and nursing home care should be paid for by coercive taxation or by individuals and families taking responsibility for themselves and planning for the future. It is the proper size and scope of government itself that lies at the basis of Medicaid reform.

Medicaid is not simply an accounting problem. It is the proper size and scope of government itself that lies at the basis of Medicaid reform.

Medicaid is complicated, costly, and rife with politics. State reformers, like their national counterparts, should be resolute and willing to demonstrate leadership. They must also learn to persuade, because unlike welfare reform, substantial changes in Medicaid are unlikely to be popular; a 1995 *Business Week* survey found that Medicaid has become a middle-class entitlement not just in fact but in conviction, with 53 percent of Americans agreeing strongly that "the federal government should guarantee nursing home care for the elderly."[132] Unless today's Medicaid reformers can persuade Americans otherwise, the political trap into which many entitlement reformers, Republican and Democrat, have walked in the past will find new victims.

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[131] Arthur Hall, "Economic Expansion Leads to Higher Taxes on Median One- and Two-Earner American Families," *Special Report No. 65*, Tax Foundation, Washington, D.C., November 1996, p. 2.

[132] "Portrait of a Skeptical Public," *Business Week*, November 20, 1995. There is some good news on the public opinion front. A GrassRoots Research survey in February 1996 found that 59 percent of respondents believed state governments should set benefit and eligibility guidelines for Medicaid, vs. 39 percent who thought the federal government should.

Former Pennsylvania Department of Aging Secretary Linda Colvin Rhodes, writing about federal entitlement reform, had this to say about the need for persuasion:

> *Some will say that the public cannot understand this complex issue—or worse, cannot confront it in anything but a self-destructive orgy of self-interest. But my experience tells me otherwise. . . Americans are willing to make sacrifices and able to make sophisticated tradeoffs, but to do this they require—and expect—straight talk and meaningful dialogue devoid of obfuscation, scare tactics, and partisan rhetoric. They haven't been getting it.*[133]

If any issue in entitlement reform necessitates straight talk and political leadership, it is the status and future of Medicaid. The American public deserves nothing less.

"You Make the Call: Restraining Medicaid Growth," *Portrait of America*, vol. 1. no. 3, February 1996, p. 1. Furthermore, 79 percent of Americans agree that "to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans." See Cashdollar.

133 Linda Colvin Rhodes, "Please, Not Another Commission," *The Wall Street Journal*, December 9, 1996, p. 14A.

Part 8

About the Author

John Hood is president of the Locke Foundation. He serves as editor and publisher of *Carolina Journal*, the Foundation's bimonthly magazine,and oversees the research, publications, and administration of the Foundation. He is also a contributing editor of *Reason* magazine, a columnist for *Policy Review* (the magazine of the Washington-based Heritage Foundation), a syndicated columnist and a contributor to such publications as *The Wall Street Journal*, *National Review*, and *Investors' Business Daily*. In 1994–95, Hood spent a year at Heritage as a Bradley Visiting Fellow, writing *The Heroic Enterprise: Business and the Common Good* (The Free Press, 1996).

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