

Guidelines for reform of the Medicaid program



EXECUTIVE SUMMARY

The purpose of this document is to present guidelines or goals that the Alliance for Advancing Nonprofit Health Care believes should serve as the foundation of studies and proposals to reform the Medicaid program. Preceding the presentation of the guidelines and commentary under each are:

- Basic information about the program as it currently exists;
- Public attitudes toward it; and
- A special note on the sequencing of decisions on Medicaid reform and private health financing reforms to reduce the number of uninsured.

In the latter regard, the Medicaid program has become in recent years, and should be viewed as, the safety net of last resort for people unable to obtain affordable coverage in the private sector or through Medicare and other public health financing programs. *Consequently, decisions on Medicaid reform should be preceded by a careful, comprehensive study and decision-making process on needed federal and state policy reforms to increase private health insurance coverage through the workplace and through state-sponsored risk pools, as well as to increase private financing mechanisms for long-term care.*

Approaching Medicaid reform in this manner will in and of itself reduce future demands on and costs of this program, although public “expenditures” would

need to increase elsewhere in the form of new tax credits, new tax deductions, and/or new or increased costs of sponsoring or administering risk pooling arrangements for individuals, small businesses, or other groups.

The Alliance's guidelines for Medicaid reform are as follows:

- I. Federal reform of the Medicaid program should not be driven by arbitrary short-term spending reduction targets.
- II. Through the Medicaid program, federal and state governments should ensure that all in need of services will be covered who are unable to secure affordable coverage under other public or private financing mechanisms.
- III. The roles of federal and state governments in Medicaid should be restructured such that:
 - A. The federal government will pay for the costs of a specific set of benefits for individuals or families meeting specific eligibility criteria; and
 - B. Each state will define and pay for the costs associated with the provision of benefits for those who remain without adequate, affordable health benefit coverage through public and private financing programs.
- IV. Any Medicaid beneficiary cost-sharing provisions, whether in the form of "premium" contributions, deductibles, and/or co-payments, should not create financial barriers to needed coverage or care.
- V. Federal Medicaid eligibility, benefit coverage and other requirements need to be reformed with a view toward:
 - A. Greater ease of understanding and ease of administration for both beneficiaries and administrators;
 - B. Eliminating the ability of some states to "game the system" in terms of what is countable for federal matching payments;
 - C. Eliminating inappropriate sheltering or transferring of assets in order to qualify for Medicaid long-term care services, while promoting reverse mortgages and instituting other public policies that encourage people to self-finance such care rather than relying on Medicaid;² and
 - D. Providing more flexibility with less burdensome review and approval processes for state innovation.

VI. Payments to health care providers and private health plans under the Medicaid program should be adequate and fair.

VII. The costs and quality of services delivered to Medicaid beneficiaries should be better controlled.

THE CURRENT MEDICAID PROGRAM

Originally conceived and legislated in the mid-60s to be a federal/state partnership for financing and administering health care services for poor pregnant women and children, the Medicaid program has expanded enormously over the past four decades to become the single largest health insurer in the U.S., now surpassing Medicare in annual spending (\$329 billion versus \$309 billion) and in number of beneficiaries (53 million versus 42 million).

On average, sixty percent³ of the costs of Medicaid are paid by the federal government, while the remaining forty percent are picked up by the states (and local governments to some degree). Medicaid has become the largest single spending item for states, now exceeding elementary and secondary school education (21.9% and 21.5% respectively), and Medicaid spending is almost double that of higher education (10.8%).

Medicaid is in effect not one program but many, with eligibility based not only on low income but also one or more of 24 categorical criteria, such that the program covers:

- Children
- Pregnant women
- Some parents other than pregnant women
- Seniors
- People with disabilities

This categorical approach makes it impossible for a state to cover low-income nondisabled adults without children (single adults and childless couples) without obtaining a federal waiver.

Mandatory services include inpatient and outpatient hospital care, physician services, nursing home services for adults, pregnancy-related services, home health care, lab and radiology services, family planning, and medically necessary services identified through well-child exams. Maximum co-pays are limited to \$3.00 for most services.

² Four states only are currently permitted to allow consumers to access Medicaid and preserve their assets once their private long-term care benefits have been exhausted.

³ Federal matching varies by state, between 50% and 77%.

Optional services include ambulance; services of chiropractors, dentists, optometrists, podiatrists, and therapists; dentures, eyeglasses, hearing aids, and medical equipment and supplies; and prescription drugs. States have broad discretion in defining the amount, duration, and scope of covered services. At the same time, however, states must have a waiver to provide more limited benefit packages to uninsured individuals with higher incomes.

Medicaid spending across population groups in relation to numbers covered varies widely:

- Children represent 48% of enrollment yet only 18% of the costs.
- Non-elderly adults represent 26% of the enrollment yet only 11% of the costs.
- Seniors represent 10% of the enrollment yet 26% of the costs.
- The blind and disabled account for 16% of the enrollment yet 44% of the costs.

Thus, the elderly, blind, and disabled represent only 26% of the enrollment yet account for 70% of the costs. The 2002 fiscal year, 42% of Medicaid spending was for low-income elderly or disabled individuals qualifying or waiting to be qualified for Medicare, with spending for these “dual-eligibles” breaking down as follows: 65% for long-term care, 15% for acute care, 14% for prescription drugs, and 6% for Medicare premiums.

Medicaid also provides \$15 billion (4.5% of its total spending) in special payments to disproportionate share hospitals (DSH).

Medicaid spending grew by almost one-third between 2000 and 2003 (10.2% per year), with the growth rate lower in 2003 (7.1%) due to slower growth in enrollment and in spending per enrollee, particularly for acute care. Spending growth over the entire three-year period was generally attributable to enrollment growth related to a downturn in the economy, with some increase in spending per capita above inflation but less than in the private insurance sector.

Despite the size of the Medicaid program, not everyone who is poor qualifies. It is estimated that it only covers 40% of Americans below the federal poverty line, with employers covering 15%, 5.9% insuring themselves, other public entities covering 3.3% and the remaining 36% uninsured.

Also, most Medicaid beneficiaries are not on welfare: an estimated 25% are receiving cash assistance now in comparison to 75% twenty years ago.

Sixty-five percent of the spending is for optional programs (not federally mandated), yet these programs can be critical in that they include coverage for:

- The medically needy (those with low incomes and high medical bills).
- The low-income disabled above the cutoff point for SSI benefits.
- Low-income elderly nursing home residents above the SSI cut-off point.
- Low-income children above the federal income cutoff qualifying them for mandatory coverage.
- Low-income pregnant women making above 133% of the federal poverty line.

For every dollar that a state decides to cut in Medicaid spending, it loses two in federal match. Over the last few years states have tended to eliminate or restrict coverage of optional services for their adult Medicaid beneficiaries as a means of moderating cost increases. At the same time, all states include both ambulance and prescription drug coverage, most cover intermediate care facilities for the mentally retarded, and most cover pregnant women at income levels above the federal minimum of 133% of the federal poverty level.

Certain Medicaid requirements can be waived with federal approval, and every state has at least one waiver. Managed care programs are operated by many states under waivers. There are some limited opportunities for states to subsidize and encourage employer-sponsored coverage.

PUBLIC ATTITUDES TOWARD THE MEDICAID PROGRAM

On June 29, 2005, the Kaiser Family Foundation released the results of a national public opinion poll of people ages 18 or older⁴ indicating that nearly 75% of adults believe that the Medicaid program is very important, ranking it close to Social Security (88%) and Medicare (83%), equal to aid to public schools, and well ahead of defense (57%) and foreign aid

⁴ The poll, conducted from April 1 to May 1, involved telephoning 1,201 individuals. The margin of error for questions asked of all respondents was estimated to be plus or minus three percentage points. For questions asked of subsets of respondents the estimated margin of error was plus or minus four percentage points.

(20%). Forty-four percent of the respondents preferred the federal government maintaining its current level of funding, 33% preferred an increase, 12% wanted a decrease, and 7% didn't know.

Seventy-four percent of respondents, when asked about their state's budget problems, cited Medicaid costs as a reason for those problems. Regarding their state's budget problems, 24% felt that programs other than Medicaid should be cut, 21% felt that taxes should be increased, and 21% said that Medicaid should be cut. The remaining 34% had other suggestions or didn't know.

A SPECIAL NOTE: SEQUENCING OF DECISIONS ON MEDICAID REFORM AND HEALTH FINANCING REFORMS TO REDUCE THE NUMBER OF UNINSURED

The Medicaid program should be viewed as the safety net of last resort for people unable to obtain affordable coverage in the private sector or through the Medicare program.

Consequently, decisions on Medicaid reform must be preceded by a careful, comprehensive study and decision-making process on needed federal and state policy reforms to increase private health insurance coverage through the workplace and through state-sponsored risk pools, as well as to increase private financing mechanisms for long-term care.

Approaching Medicaid reform in this manner will in and of itself reduce future demands on and costs of this program, although public "expenditures" would need to increase elsewhere in the form of new tax credits, new tax deductions, and/or new or increased costs of sponsoring or administering risk pooling arrangements for individuals, small businesses, or other groups.

MEDICAID REFORM GUIDELINES

I. Federal reform of the Medicaid program should not be driven by arbitrary short-term spending reduction targets.

Neither the beginning point nor the end point for a study of Medicaid reform should be based on arbitrarily established fiscal targets to meet short-term budget constraints. Rather,

decisions on future spending should flow from the development and analysis of sound alternative approaches to long-term improvement of the program.

II. Through the Medicaid program federal and state governments should ensure that all in need of services will be covered who are unable to secure affordable coverage under other public or private financing mechanisms.

Our nation and its leaders must have the moral courage and will to ensure that all American residents have access to affordable coverage to meet acute, chronic, and long-term care needs through the private sector, Medicare, or Medicaid.

III. The roles of federal and state governments in Medicaid should be restructured such that:

A. The federal government will pay for the costs of a specific set of benefits for individuals or families meeting specific eligibility criteria; and

B. Each state will define and pay for the costs associated with the provision of benefits for those who remain without adequate, affordable health benefit coverage through public and private financing programs.

Under the current program, the federal government pays for more than half of the costs of optional benefits and optional eligibility groups decided upon by the individual states. This can result in some states receiving disproportionately more federal financial support because they are financially healthier and more likely to be able to pay their share of the costs of these options. This appears contrary to the original intent of the program, wherein the federal government would provide proportionately more funding to states that were financially poorer.

IV. Any Medicaid beneficiary cost-sharing provisions, whether in the form of "premium" contributions, deductibles, and/or co-payments, should not create financial barriers to needed coverage or care.

Some changes being proposed by one or more groups (e.g., National Governors Association, HHS, Council of State Legislatures) would give states broad discretion to establish enforceable premiums, deductibles, or co-pays, with or without an upper limit on such cost sharing (e.g., 55% of

total household income) for various categories of Medicaid beneficiaries. Medicaid beneficiary cost sharing requires careful study, as some recent research results (e.g., Oregon’s Medicaid program) indicate significant negative impacts on needed coverage or care.

V. Federal Medicaid eligibility, benefit coverage, and other requirements should be reformed with a view toward:

- A. Greater ease of understanding and ease of administration for both beneficiaries and administrators;**
- B. Eliminating the ability of some states to “game the system” in terms of what is countable for federal matching payments;**
- C. Eliminating inappropriate sheltering or transferring of assets in order to qualify for Medicaid long-term care services, while promoting reverse mortgages and instituting other public policies that encourage people to self-finance such care rather than relying on Medicaid;⁵ and**
- D. Providing more flexibility with less burdensome review and approval processes for state innovation.**

Some changes being proposed by one or more groups (e.g., National Governors Association, HHS, Council of State Legislatures) that require careful study include:

- Eliminating all of the categorical eligibility criteria in favor of eligibility based solely on income, and
- Giving states broader flexibility in setting the benefit package for different Medicaid population groups, as has been allowed under the SCHIP program.

VI. Payments to health care providers and private health plans under the Medicaid program should be adequate and fair.

For more than a decade, since the federal government eliminated its requirement that payments by state Medicaid programs to health care providers had to bear a reasonable

relationship to the costs incurred, health care providers have typically had to subsidize the costs of caring for Medicaid beneficiaries. In fact, because there is no separate private safety net for various social services (e.g., long-term care) being promised under the Medicaid program, health care providers or insurers have typically had to serve as the private safety net for both health care and social services over-promised by Medicaid programs, as well as serve as the private safety net for the uninsured.

Underpayment has also been illustrated in various states by reductions in private health insurer participation in Medicaid managed care programs.

To their credit, the Medicare and Medicaid programs have included special payments for hospitals, other providers and/or health plans with a disproportionate share of Medicaid or low-income patients, but these fixes often fall far short of adequate and equitable payment for all.

VII. The costs and quality of services delivered to Medicaid beneficiaries should be better controlled.

Some changes that are being proposed by one or more groups that require careful study include:

- A. Reducing the costs of drugs through increased rebates from manufacturers or other means;
- B. Increasing the ease with which states can obtain managed care or other waivers intended to reduce costs or improve quality; and
- C. Increasing funding to states for demonstration projects using information technology to help improve quality and reduce costs, with or without establishment of pay-for-performance contractual arrangements with health care providers.

⁵ Four states only are currently permitted to allow consumers to access Medicaid and preserve their assets once their private long-term care benefits have been exhausted.