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TESTIMONY

Medicaid Eligibility: Who Should and Should Not be Covered and Why

Testimony before
The Medicaid Commission

January 25th, 2006

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My name is Nina Owcharenko. I am a Senior Policy Analyst at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you for the invitation to speak to you today about Medicaid eligibility and reform.

It is impossible to look at Medicaid, and especially Medicaid reform, in isolation from the rest of the health care system. Issues such as the uninsured, the decline in employer based coverage, and the overall cost of health care coverage are all intertwined with the Medicaid program. However, instead of simply accepting the changing nature of Medicaid and the health care system, it is important to ask three questions: 1) what is the proper role of Medicaid, 2) has the program expanded eligibility beyond its ability to provide quality care for those most in need and 3) are there other policy solutions may help to alleviate the increasing burdens on the Medicaid program.

Eligibility Trends

The federal-state partnership makes the Medicaid program unique. The federal government requires states to cover certain "mandatory" populations, but also allows states to expand eligibility beyond the mandatory requirements and extend Medicaid to "optional" groups. Federal waivers also give states even further discretion over the scope and structure of the program. Today, Medicaid provides care to over 50 million individuals with very diverse needs. Medicaid provides care for moms and kids, blind/disabled, elderly, and poor adults. Therefore, there is not a single Medicaid program, but instead 50 state variations, each which vary further by categories of people and income levels.

Over the years, states have expanded their Medicaid programs beyond the traditional "mandatory" populations, and many have also utilized the waiver process to make additional changes to their programs. During times of economic prosperity and surpluses, many states find it both politically and economically attractive to expand Medicaid. Encouraged by the federal matching structure, states see it as an opportunity to expand access to health care. For every state dollar, the state receives a federal matching contribution. Thus, the Medicaid program becomes a tool by which states can expand access on an incremental basis and receive financial rewards for doing so.

As attractive and easy it is for states to expand Medicaid during periods of economic growth, the opposite is true during economic downturns. The logical reaction when funds are tight is to reduce eligibility back to traditional levels. However, the political and financial consequences of reducing eligibility are difficult to overcome. News reports of cutting individuals and families, regardless of income levels, certainly influence decisions. Both Tennessee and Missouri have recently been on the receiving end of such criticisms. Moreover, there is a financial disincentive for states to cut eligibility – for every state dollar cut, the state will also lose its corresponding federal match.

Thus, after expansions, states are left with trying to provide care to more people under tight fiscal budgets while struggling to meet equally important and competing priorities.

As the National Governor's Association has pointed out, Medicaid is now the largest part of state budgets accounting for approximately 22 percent. These demands by Medicaid crowd out other important state priorities such as education, transportation, and infrastructure costs like homeland security.

There is no escaping the need for states to contain the cost of the growing Medicaid program. States have used a variety of techniques to avoid direct eligibility changes, instead employing indirect cost containment measures that ultimately impact the quality of care delivered by the program. Freezing or reducing provider payments and imposing restrictions on prescription drugs are two of the most common practices. Unfortunately, such techniques prevent Medicaid beneficiaries' access to critical prescription drugs and reduce the number of physicians, both general and specialty, who are willing at accept Medicaid patients. In other words, Medicaid must ration needed services and force Medicaid enrollees to accept substandard care in order to control and contain costs.

However, these administrative adjustments do not get at the fundamental conflict inherent in trying to provide quality care under an ever-expanding program. In the end, as states expand eligibility further up the income levels, both the quality of care and the range of services available to those truly in need are at risk. It is evident that Medicaid is spread too thin and can sustain its current form only by further rationing care, and thereby adversely affecting the care for those most vulnerable. In order to tackle the Medicaid problem, it is important to decide 1) what is the proper role for Medicaid; 2) how best to refocus the program on those who need it most; and 3) what other policy initiatives can be adopted to help reduce the burden on an already overstretched Medicaid program.

It is apparent that Medicaid eligibility has expanded beyond its original purpose and will have difficultly maintaining stability into the future. This should be alarming to those who believe in Medicaid's primary focus of providing quality care to those most vulnerable. Therefore, new policy initiatives must be developed and advanced in order to address the needs of others, such as the working poor, and preserve the future of the health care system.

Recommendations

There are many ways to help refocus the current direction of the Medicaid program. Here are a few principles and ideas to consider:

Ideally, any discussion on Medicaid reform should start with a review of the current federal-state matching structure to see if it is effectively distributing funds to those states and people most in need. Short of overhauling that structure, attention should be given to improve the flow and transparency of the current dollars. Today, Medicaid dollars are provider-centered rather than patient-centered. A better system would be to tie Medicaid dollars directly to an individual. A "dollars-follow-the-patient" concept would give patients choice and create a direct correlation between individual health care needs and the federal/state contributions they receive. Meaning, those individuals with higher health care costs could receive a greater allotment. This would ensure that eligibility and funds

better reflect individual needs. Florida is testing and South Carolina is exploring such concepts.

Second, states should be given greater flexibility to make adjustments to their Medicaid programs. Based on the successful welfare reform model, state should have broad authority to make changes to their programs in exchange for meeting basic federal outcome measures and costs. For example, states should be able to make adjustments to benefit packages and cost sharing requirements based on categories and income levels. There is certainly a difference between someone at 200 percent FPL and someone at 20 percent FPL, and states should be able to set policy to reflect those differences. Many states are already taking advantage of existing waiver authority to make broader changes to their Medicaid programs, but it is a burdensome and complex process.

Third, there should be a simplified process for directing Medicaid dollars toward private health care coverage options. Instead of enrolling into Medicaid itself, eligible individuals should be able to elect to receive a subsidy from Medicaid to purchase private health insurance coverage, whether through the place of work or on their own. A mother, for example, whose child is eligible for Medicaid, could choose to have her child receive a Medicaid subsidy that would purchase dependent coverage at the place of work. It could be based on a sliding scale to gradually streamline people off the subsidy as their incomes rose. It can also prevent crowd out, where public program expansions replace existing private coverage options. A recent study by researchers at the Urban Institute found that the Medicaid premium assistance program in Massachusetts actually preserved private coverage enrollment.[1] This approach would help mainstream many working families and individuals into private health care coverage.

Fourth, the cash and counseling model should be applied to other Medicaid populations, especially as a way to improve care management. The cash and counseling model allows states to give certain disabled individuals the power to manage their personal care services. With assistance from a care counselor, individuals and family members select services based on a budget. Evaluations have shown that these individuals are more satisfied with their services and overall lives under this approach.[2] The concept of engaging enrollees in managing their own choices, with appropriate oversight, instead of being dictated care by the Medicaid system, could have wide applicability throughout the Medicaid program.

Besides modifying Medicaid, there are other non-Medicaid policy initiatives that could help to relieve the pressure on the program and give low-income individuals private coverage alternatives to Medicaid.

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[1] Sharon Long, Stephen Zuckerman, and John A. Graves, "Are Adults Benefiting from State Coverage Expansions," *Health Affairs Web Exclusive*, January 17, 2006, at http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w1v1.

[2] Leslie Foster, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson,"Improving the Quality of Medicaid Personal Assistance Through Consumer Direction," *Health Affairs Web Exclusive*, March 26, 2003 at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.162v1.

First, a health care tax credits would give lower-income individuals a direct federal subsidy to help them purchase private health care coverage. The credits would be refundable, meaning even those who owe little to no taxes would receive the full credit amount. The credit would also be advanceable, meaning the individual could claim the credit up front when insurance premiums were due rather than wait until the end of the year for reimbursement. This is a particularly important feature for low-income individuals with limited disposable income, which the credit is intended to relieve. Finally, the credit would be assignable so that the subsidy would be forwarded directly to the insurer.
In lieu of Medicaid expansions, a refundable tax credit could make private health care coverage a reality for many working poor individuals and families.

Hand-in-hand with a tax credit, policies to increase access to affordable health care coverage are also important. Federal efforts, such as the Health Care Choice Act introduced by Representative John Shadegg (R-AZ), which would allow individuals to purchase health care coverage across state lines, would enable individuals to purchase health insurance they find affordable and create an incentive for insurers to compete based on value.

There are also state efforts underway aimed at creating affordable coverage options. Massachusetts, for example, has a comprehensive approach to ensuring access to affordable private health care coverage.

Finally, there are proposals emerging based on a broader federal-state partnership. Stuart Butler, Vice President at the Heritage Foundation, and Henry Aaron with the Brookings Institution are exploring the idea of "creative federalism."[3] A concept which goes beyond the silos of the current health care system and encourages states to develop and test comprehensive approaches to overall health care reform. These could include public program initiatives, private coverage initiatives, and other innovative approaches to coverage. Empowering states to experiment may be an attractive solution for some state and federal policymakers.

To conclude, Medicaid eligibility has expanded beyond its original scope. This is due in part to well-intentioned state efforts to help low-income individuals and families, as well as the growing number of uninsured. However, by doing so, the program has spread itself too thin, jeopardizing the quality of care enrollees' receive. One of the best ways to address the problems facing the Medicaid program and the overall health care system is to look beyond the status quo and advance other policy initiatives that can help reduce the burden on Medicaid and allow the program to better serve those who need it most.

Thank you again, and I look forward to the discussion.

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[3] Henry J. Aaron and Stuart M. Butler, "How Federalism Could Spur Bipartisan Action on the Uninsured," Health Affairs Web Exclusive, March 31, 2004 at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.168v1.

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