

# Toward Real Medicaid Reform

Four options to provide the financial redesign Medicaid needs without sacrificing its protections for vulnerable Americans.

by **John Holahan and Alan Weil**

**ABSTRACT:** In this paper we argue that there is a real need for Medicaid reform primarily because of the large differences among states in coverage and benefits and because of the program's high and rising costs. We describe and develop several options for Medicaid reform that would expand coverage, provide fiscal relief to states, shift responsibility for some or all of the care of dual eligibles to the federal government, and eliminate or restructure disproportionate-share hospital (DSH) payments. We conclude with a discussion on a number of other issues, particularly Medicaid cost containment and the federal matching payment structure. [*Health Affairs* 26, no. 2 (2007): w254–w270 (published online 23 February 2007; 10.1377/hlthaff.26.2.w254)]

C ONCERN WITH THE RISING COST OF MEDICAID is becoming increasingly widespread. The Deficit Reduction Act (DRA) of 2005 made important changes to Medicaid; the Bush administration has solicited and approved Section 1115 waivers that modify core features of the program; many states have active Medicaid reform commissions; and health and human services (HHS) secretary Michael Leavitt created a commission to consider fundamental reforms. The primary focus of much of this activity has been on controlling the rate of spending increase. Although Medicaid spending growth seems to have slowed in 2006, program spending remains a major long-term policy concern.

Medicaid provides a wide range of acute and long-term care services (at some point during the year) to more than fifty million children, parents, disabled people, and elderly people. It forms a large part of the health care safety net. But the program has several structural problems, including widespread differences among states in coverage, strains on states' ability to cope with rising costs, and a series of questionable financing arrangements that have soured federal and state relations with regard to program administration.

In this paper we lay out broad strategies for fundamental reform of the Medicaid program, including describing and providing cost estimates for four different approaches to fundamental reform. We are under no illusion that what we propose is politically feasible in the current environment, but we believe that those

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*John Holahan (jholahan@ui.urban.org) is director of the Health Policy Center, Urban Institute, in Washington, D.C. Alan Weil (aweil@nashp.org) is executive director of the National Academy for State Health Policy in Portland, Maine, and Washington, D.C.*

pursuing true reform must wrestle with the issues we raise.

In our opinion, many of the ideas emerging from the reform proposals currently on the table are appropriate, such as increased emphasis on wellness and prevention; improving care coordination for higher-need populations, including dual eligibles; and investing in information technology (IT). But we also believe that there is much in the DRA and recently approved waivers that represents the wrong approach to Medicaid cost containment and is not true reform.

### **Problems With Current Reform Proposals**

In our view, many of the proposals for Medicaid reform now being discussed and implemented rely on a series of mistaken assumptions and beliefs about why Medicaid costs so much. Specifically, a major thrust behind “Medicaid reform” has become concern regarding overuse of services by enrollees.<sup>1</sup> This concern is reflected in a variety of views expressed by certain reform proponents. Some of the alleged overuse is attributed to “moral hazard”—the notion that when people do not face the actual price of goods or services that they use, they will consume more than is appropriate. Others speak of the “Cadillac” Medicaid benefit package, which covers some services generally excluded from commercial insurance and in many states lacks numeric service limits on benefits such as physical therapy.<sup>2</sup>

From this diagnosis, a series of policy responses naturally follows: increasing cost sharing for enrollees, particularly at the point of service; scaling back the benefit package (at least for some populations) to exclude certain services; or capping services such as the number of prescriptions that can be filled each month. For some reform advocates, the appropriate response is even more fundamental change, such as extending the use of high-deductible insurance policies paired with health savings accounts (HSAs) for the very-low-income Medicaid population, with a primary goal of making enrollees more conservative purchasers.<sup>3</sup>

The notion that a central principle of Medicaid reform should be giving enrollees financial incentives to reduce use ignores the long-standing reality that enrollees have difficulty finding health care providers who will accept Medicaid.<sup>4</sup> Research consistently shows that Medicaid enrollees have access and utilization levels comparable to those of the privately insured when differences in the populations are controlled for.<sup>5</sup> In addition, these proposed policies are usually suggested for low-income parents and children, not for elders and people with disabilities. But parents and children on Medicaid are already mostly enrolled in managed care plans, which have systems designed to reduce unnecessary use. These enrollees also account for only 31 percent of Medicaid spending, which means that even if the policies have their intended effect, they will have a limited effect on overall Medicaid costs.<sup>6</sup>

Yet efforts to reduce benefits and increase cost sharing persist, primarily because they seem likely to save money in the short run. Indeed they may, but their implications go well beyond cost. The response to higher cost sharing and limited

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benefits will be lower use, which could lead to increases in unmet need and negative health consequences, particularly for people with chronic conditions.<sup>7</sup>

In addition, reform proposals based on shifting costs to enrollees are not likely to do much to control program spending. The real reason for the recent growth in Medicaid spending has been enrollment growth among families and children because of the recession and growing income inequality, growth in the number of disabled enrollees because of the increasing incidence and recognition of disability, and medical care inflation in the health sector.<sup>8</sup> Medicaid costs are not high compared with other kinds of insurance on a risk-adjusted basis.<sup>9</sup> Research has shown that when health status, disability, and chronic illness are controlled for, Medicaid costs less per enrollee than private insurance. Medicaid programs have contained costs, on a risk-adjusted basis, through aggressive controls on provider payment rates and the use of managed care. Additional cost containment in Medicaid must be focused on the management of the chronically ill and disabled populations that account for a large share of program spending and a disproportionate share of spending growth.

### **Need For Medicaid Reform**

Despite our critique of current proposals for Medicaid reform, we do believe that the program needs reform, for at least four reasons. First, Medicaid program costs and cost growth are a growing burden for states; given this fact, states will regularly be forced to make marginal cutbacks in coverage and benefits that will harm beneficiaries, undermine the goals of the program, and increase the number of uninsured Americans. Medicaid costs per enrollee are not high in comparison to the private market; however, Medicaid enrollment growth coupled with medical care inflation is clearly forcing health care spending to increase at a rate that states find difficult to manage. States probably cannot continue to support Medicaid as well as other priorities, such as infrastructure and education. Some fiscal relief needs to be part of any serious federal Medicaid reform effort. A reformed Medicaid program should recognize the broader taxing and borrowing authority of the federal government and the greater volatility of state revenues and place more of the cost and the risk for cost growth onto the federal government.

Second, interstate variations in the Medicaid program, particularly with respect to coverage and provider payment rates, are too great given the dominant funding role of the federal government and the national interest in providing for the health care needs of low-income families, elders, and people with disabilities.<sup>10</sup> A reformed Medicaid program should reduce interstate variation in eligibility and provider payment. These changes would reflect the national interest in a solid,

uniform base of coverage for the poor and make it easier for Medicaid or other programs to build upon that base to further reduce the number of uninsured people.

Third, complex, restrictive federal eligibility standards contribute to the large number of people who are eligible but not enrolled and divide families in ways that make it difficult to build on the base of Medicaid coverage with tax credits, subsidized coverage, integration with employer-sponsored insurance, or any mechanism designed to reduce the number of uninsured Americans.

Fourth, the current program design contains features that promote mistrust between states and the federal government regarding whether Medicaid funds are being used to achieve the program's purposes. Specifically, the use of disproportionate-share hospital (DSH) payment, upper payment limit (UPL) programs, and other similar mechanisms in which state financial participation has been questionable has clearly soured federal-state relations.<sup>11</sup> In a reformed program, the financing arrangements that states have used to leverage higher federal matching payments with little or no state contribution should be eliminated.

Given these problems, we identify some critical features of reform that should appear in any proposal. Below we describe four options that would provide a mix of coverage expansion, shifting some populations or services to the federal government while shifting other populations or services to states, increasing matching rates, and DSH reform. We then model the impact of these four options on Medicaid and its populations. In the final section we discuss other issues, including cost containment and reform of the federal matching formula. These are not included in the modeling results but nonetheless merit serious attention.

The expansion of coverage up to a national minimum eligibility standard would increase uniformity of Medicaid coverage among states and reduce the number of uninsured low-income Americans, particularly in states that now have more limited Medicaid coverage. Shifting populations or services to the federal government would provide states with fiscal relief and increase the federal government's incentives to invest in care management for these populations. Shifting other populations or services to states would make states wholly responsible for these services, potentially improving system efficiency, and would offset federal costs from the shift of other services to the federal government. Increasing federal matching rates would provide fiscal relief and increase incentives for states to add coverage and provide adequate benefits and to avoid punitive reductions in coverage and benefits. Reform of DSH payments, UPL programs, and other similar programs in which states make little or no real contribution but can leverage federal dollars would curtail the inappropriate use of federal outlays.

These reforms would be relatively costly to the federal government but would restructure Medicaid and address its key problems. Each of the options described below have approximately the same budget impact on the federal government and savings to the states. They differ in their relative emphasis on coverage expansion, acute or long-term care, and federal and state responsibilities. The idea is to sim-

ply show that there are different ways to achieve major reform; indeed, reformers could obviously pick and choose policy changes within the four options.

■ **Reform option one.** The first two options expand eligibility for coverage to 150 percent of the federal poverty level. The first option would end the State Children's Health Insurance Program (SCHIP), and children's coverage would be integrated with Medicaid, with no enrollment caps; premiums such as those in the present SCHIP would be allowed. Coverage of adults would be expanded to 150 percent of poverty with a 30 percent enhanced match. States could expand further for children and adults at the enhanced matching rates. Federal matching rates on all acute care services for current beneficiaries would be increased by 30 percent; there would be no change in matching rates for long-term care. The federal government would be responsible for Medicare premiums and cost sharing for Medicare acute care services. The current "clawback" policy for prescription drugs would remain in place. Because of the broad coverage expansion, DSH payments would be eliminated.

■ **Reform option two.** The second option, similar to the first, equalizes matching-rate increases across services and programs. Federal matching rates for all services including long-term care would increase by 15 percent. SCHIP would also be retained in its current form but with the matching rate reduced to 15 percent above current Medicaid rates. Coverage of adults would be expanded to 150 percent of poverty with a 15 percent enhanced match. States could expand further for both adults and children at the 15 percent enhanced match. Acute care services for dual eligibles, including state clawback payments, would become the responsibility of the federal government, and DSH payments would be eliminated.

■ **Reform option three.** The third option would expand coverage for adults only to 100 percent of poverty, allowing states to go further if they choose. The current Medicaid/SCHIP structure for children would be retained. The federal government would be responsible for acute care services for dual eligibles, including eliminating the drug clawback. Matching rates for acute care services would remain at current levels. To help states with the looming costs of long-term care, matching rates for these services would increase by 30 percent. Because the mandatory coverage expansion would be less, DSH would not be eliminated but rather restructured with a new formula that would be based on the number of low-income people and potentially the number of recent immigrants.

■ **Reform option four.** The last option is perhaps the most dramatic. It would federalize all care for dual eligibles, including long-term care; this would not include acute care services not now covered by Medicare. The prescription drug clawback payment would be eliminated. Long-term care services for non-dual eligibles would be wholly the responsibility of states. The current Medicaid/SCHIP structure for children would be retained. Coverage of parents and nonparents would be expanded to 100 percent of poverty; states could expand further with current federal matching payments. The current matching payments on all Medicaid services would be retained; states could expand at the current matching rates. DSH would

be restructured, not eliminated.

■ **Changes common to all four options.** Certain other changes would be consistent across all four options. First, prescription drugs would become a mandatory benefit. In reality, all states now use the option to provide prescription drugs coverage, so this would be a minor change. Second, there should be increased flexibility in cost sharing above 150 percent of poverty with nominal copayments below this level. Cost sharing would be limited to a certain percentage of income: for example, 5 percent cost sharing at income levels of 150–200 percent of poverty, and perhaps higher cost sharing at higher income levels. States would have the flexibility to limit coverage to the current set of mandatory benefits, including prescription drugs, for adults. There would be less flexibility on the benefit package for children and the disabled. Medicaid’s current Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children would be retained. States would also be allowed to have enrollment caps for the new optional nondisabled adult populations: those above the mandated minimum income levels.

Third, all of the options would federalize Medicare premiums and cost sharing for Medicare acute care services. For the remaining Medicare acute care benefits, such as dental care, podiatry, optometry, and so forth, there would be three alternatives: (1) The federal government could establish a broader benefit package for low-income people—say, those below 150 percent of poverty—fully relieving states of this responsibility. (2) The states could be responsible for covering the remaining services with no federal matching payments. (3) States could continue to cover the remaining services on their own with federal matching payments, as today. The cost estimates presented below assume the third option.

## Modeling The Effects: Data And Methods

■ **Coverage impacts.** To estimate the impact of Medicaid expansions on coverage and the reductions in other types of insurance or numbers of uninsured people, we used a detailed spreadsheet model that began with a baseline of current coverage in 2004. We organized the U.S. population by group (children, parents, childless adults); by income; by current insurance arrangement; and by four geographic regions. We modeled current eligibility for public programs in great detail for each state. We then applied take-up rates to each group based on the prevailing research literature on the changes in coverage that are likely to occur among the uninsured, varying by whether people are children, parents, or childless adults and by income.<sup>12</sup> We also relied on the extensive literature on the effects of public expansions on the crowding out of private coverage.<sup>13</sup>

We estimated the cost of coverage based on Medicaid spending data from the Medicaid Management Information System (MMIS) for 2002, adjusted forward by data from the Centers for Medicare and Medicaid Services (CMS) Form 65 data and Congressional Budget Office (CBO) projections. We further adjusted these costs for the expected better health status of the newly enrolled popula-

tion.<sup>14</sup> Because we assumed a reduced a benefit package for adults, we made a further downward adjustment (7.5 percent) to the costs of care for that population.<sup>15</sup> With the baseline, our estimates of take-up and crowd-out rates, and our estimates of the cost of coverage, we generated the change in costs for any eligibility expansion for each of the three groups by income and by region.

■ **Changes in matching rates and federalizing parts of Medicaid.** To estimate the effects of these kinds of policy changes, we organized Medicaid spending data again based on the 2002 MMIS, adjusted forward to 2006 based on CMS 64 data for 2004 and CBO projections to 2006.<sup>16</sup> We organized spending by acute care, long-term care, and prescription drugs, by each of the four eligibility categories as well as separately for dual and non-dual eligible elderly and nondisabled people. Drugs were separated from acute care because of the different treatment of drugs for dual eligibles. To project DSH payments forward, we used CBO estimates for 2006. SCHIP spending data were also based on CBO estimates for 2006.<sup>17</sup> We then adjusted matching rates for different populations or services, and we estimated the cost to federal and state governments. This approach also allowed us to estimate impacts by region, which is important because states differ so much in both baseline coverage and spending on different services.

## Results: Specific Policy Options

The costs of the four options are discussed below. Each has a number of components; several, such as increasing matching rates, are straightforward and are not discussed. Other components merit brief discussion.

■ **Changes in coverage.** Exhibit 1 shows the effects of mandatory coverage expansions. With an expansion to 100 percent of poverty using current take-up rates, Medicaid enrollment would increase by 7.1 million—1.9 million of whom would have previously had private coverage, and 5.2 million of whom would have been uninsured. More than half of the new enrollees would be childless adults. The overall cost to the government would be \$24.1 billion. At current matching rates, the cost to the federal government would be \$14.0 billion and to state governments, \$10.0 billion. With a 30 percent enhanced match, federal spending would increase \$18.2 billion and state outlays, \$5.9 billion (at a 15 percent enhanced match, the comparable numbers are \$16.1 billion federal and \$8.0 billion state). Expansion to 150 percent of poverty has even greater effects (Exhibit 1).

■ **Federalizing components of Medicaid.** The four options contain different proposals for federalizing care for dual eligibles. The intent is to shift costs to the federal government, with the hope that this would improve care coordination and also provide substantial fiscal relief to states. We estimated how much federal spending would increase if the federal government kept current policies in place. It is likely that the federal government would restructure policy given its increased responsibilities, and this would change overall spending as well as spending patterns among states. We did not estimate the impact of such changes. If the federal govern-

**EXHIBIT 1**  
**Effects Of Medicaid Expansions: 2002–2005**

| Coverage source/cost                   | Percent of federal poverty level |        |
|--|----------------------------------|--------|
|  | 100%                             | 150%   |
| Change in coverage (millions)          |                                  |        |
| Medicaid                               | 7,070                            | 11,117 |
| Children                               | 1,097                            | 1,550  |
| Parents                                | 1,258                            | 2,747  |
| Childless adults                       | 4,715                            | 6,820  |
| Employer                               | -924                             | -1,861 |
| Nongroup                               | -967                             | -1,477 |
| Uninsured                              | -5,167                           | -7,779 |
| Cost to government (\$ billions, 2006) |                                  |        |
| Children                               | \$24.1                           | \$38.1 |
| Parents                                | 2.3                              | 3.2    |
| Childless adults                       | 4.6                              | 10.0   |
|  | 17.2                             | 24.9   |
| Matching rates (\$ billions, 2006)     |                                  |        |
| Regular                                |                                  |        |
| Federal                                | \$14.0                           | \$22.2 |
| State                                  | 10.0                             | 15.9   |
| 15 percent higher                      |                                  |        |
| Federal                                | \$16.1                           | \$25.5 |
| State                                  | 8.0                              | 12.6   |
| 30 percent higher                      |                                  |        |
| Federal                                | \$18.2                           | \$28.9 |
| State                                  | 5.9                              | 9.2    |

**SOURCES:** Authors' calculations based on population information from the March 2005 Current Population Survey and cost data from the 2002 Medicaid Management Information System (MMIS).

**NOTE:** Cost data were adjusted to 2006 using the CMS-64 and Congressional Budget Office (CBO) projections (March 2006 CBO baseline).

ment were to take over full responsibility for Medicare premiums and Medicare cost sharing on acute care services but retain the current clawback policy on prescription drug coverage, the effect would be to shift \$7.5 billion from the states to the federal government.<sup>18</sup> If the federal government were to federalize all acute care services for dual eligibles, including eliminating the clawback payment, \$14.1 billion would be shifted from the states to the federal government. If the federal government were to take responsibility for all care for dual eligibles, including prescription drugs, long-term care, and current services not covered by Medicare (through, say, establishing a broader set of benefits for low-income people), federal spending would increase \$47.9 billion, with states saving a comparable amount.

■ **Eliminating or restructuring DSH payments.** We modeled two policies for changes in DSH spending: first, that DSH would be eliminated, and second, that it would be restructured. Under the first assumption, federal spending would go down. The effect on state spending would be uncertain. First, states might cut back their own spending because there were no federal matching payments. Second, there might be no change in state spending because hospitals are highly dependent

on these funds. Third, there might also be no change in reported spending because the states finance this through intergovernmental transfers (IGTs) or other mechanisms that cause the state not to use real own-source funds. Fourth, states might be forced to increase spending because of hospital needs. In the estimates below, we assumed that there was no change (reduction or increase) in reported state DSH spending.

If DSH were restructured, some states would gain additional DSH dollars, assuming that they came up with state matching payments. Others would lose federal spending and could in principle reduce state spending. We assumed that states that gained new federal DSH dollars would put up state matching payments, thus increasing their spending. States that lost federal dollars would, as assumed above, maintain current efforts. Thus, the impact of restructuring DSH payments would be no change in federal spending but a net \$1.9 billion increase in state spending.

Exhibit 2 shows the results for each of the four options. All of the options would increase federal spending and reduce states' current spending by lesser amounts. All of the net increase would be due to coverage expansions that reduced the number of uninsured people. In the case of the broader coverage expansions, the reductions in federal DSH payments would partially offset the cost of the coverage expansion. The increase in federal costs would range from \$41.1 billion to \$48.7 billion. Each policy option also would provide substantial fiscal relief to states: State savings would range from \$15.1 billion to \$22.8 billion. The overall cost to the government as a whole would range from \$25.9 billion to \$29.7 billion. This is the net cost of both a sizable coverage expansion and an improvement in Medicaid's financial structure and does not include savings to various recipients of current Medicaid payments.

■ **Option 1.** Option 1 consists of a broad coverage expansion and sizable matching-rate increases. Federal spending would increase \$44.8 billion and state spending would fall \$15.1 billion. The cost of the coverage expansion would be \$28.9 billion for the federal government and \$9.2 billion for the states. The integration of SCHIP with Medicaid (eliminating enrollment caps) would add \$0.5 billion to federal outlays and \$0.2 billion to state outlays. The various changes in matching rates would increase federal spending by \$24.5 billion and would provide a comparable level of savings to states. Option 1 would federalize Medicare premiums and cost sharing but retain the current policy on the prescription drug clawback; this would shift \$7.5 billion from the states to the federal government. The reduction in DSH payments would save the federal government \$9.1 billion; states' DSH spending is assumed to be unchanged.

■ **Option 2.** Option 2 has the same coverage expansion to 150 percent of poverty but smaller increases in matching rates, applying them to long-term care services as well as to acute care. Option 2 would increase federal spending by \$45.3 billion while reducing state outlays by \$16.3 billion. The coverage expansion would be accompanied by a 15 percent enhanced match. Thus, the increased cost to the federal

**EXHIBIT 2**  
**Summary Of Medicaid Expansion Simulation Results, Spending In Billions Of Dollars, 2006**

|  | Federal (\$) | State (\$)   | Total (\$)  |
|--|--------------|--------------|-------------|
| <b>Option 1</b>  |              |              |             |
| Expand coverage of adults to 150% of poverty with 30% enhanced match                                 | 28.9         | 9.2          | 38.1        |
| End SCHIP, integrate with Medicaid, no enrollment caps   | 0.5          | 0.2          | 0.7         |
| Increase federal match for acute care services for non-duals by 30%                                  | 6.0          | -6.0         | 0.0         |
| Increase federal match for adults and children by 30%  | 10.4         | -10.4        | 0.0         |
| Federalize Medicare premiums and cost sharing for acute care; retain current policy on drug clawback | 7.5          | -7.5         | 0.0         |
| States continue to cover other services for duals with 30% federal match increase                    | 0.6          | -0.6         | 0.0         |
| LTC: no change in matching rates   | 0.0          | 0.0          | 0.0         |
| Eliminate DSH  | -9.1         | 0.0          | -9.1        |
| <b>Total</b>   | <b>44.8</b>  | <b>-15.1</b> | <b>29.7</b> |
| <b>Option 2</b>  |              |              |             |
| Expand coverage to 150% of poverty with 15% enhanced match;  | 25.5         | 12.6         | 38.1        |
| Lower SCHIP to 15% enhanced match  | -0.7         | 0.7          | 0.0         |
| Increase match for acute care and LTC for non-duals by 15%   | 4.5          | -4.5         | 0.0         |
| Increase match for acute care and LTC, adult and children by 15%                                     | 5.2          | -5.2         | 0.0         |
| Increase match for LTC for duals by 15%  | 4.8          | -4.8         | 0.0         |
| Federalize acute care for duals, eliminate clawback  | 14.1         | -14.1        | 0.0         |
| States continue to cover other services for duals with 15% federal match increase                    | 0.3          | -0.3         | 0.0         |
| Eliminate DSH  | -9.1         | 0.0          | -9.1        |
| <b>Total</b>   | <b>44.6</b>  | <b>-15.6</b> | <b>29.0</b> |
| <b>Option 3</b>  |              |              |             |
| States expand coverage for adults to 100% of poverty with no change in federal match                 | 14.0         | 10.0         | 24.0        |
| Federalize acute care for duals, eliminate clawback  | 14.1         | -14.1        | 0.0         |
| States continue to cover other services for duals with no change in federal match                    | 0.0          | 0.0          | 0.0         |
| Increase federal match for LTC by 30%  | 13.0         | -13.0        | 0.0         |
| Restructure DSH  | 0.0          | 1.9          | 1.9         |
| <b>Total</b>   | <b>41.1</b>  | <b>-15.3</b> | <b>25.9</b> |
| <b>Option 4</b>  |              |              |             |
| States expand coverage for adults to 100% of poverty   | 14.0         | 10.0         | 24.0        |
| Current match for all Medicaid services  | 0.0          | 0.0          | 0.0         |
| Federalize all care for duals; eliminate clawback  | 47.7         | -47.7        | 0.0         |
| Restructure DSH  | 0.0          | 1.9          | 1.9         |
| States responsible for LTC for non-duals   | -13.2        | 13.2         | 0.0         |
| <b>Total</b>   | <b>48.5</b>  | <b>-22.6</b> | <b>25.9</b> |

**SOURCES:** Authors' calculations based on population information from the March 2005 Current Population Survey and spending data from the 2002 Medicaid Management Information System (MMIS).

**NOTES:** Spending data were adjusted to 2006 using the CMS-64 and Congressional Budget Office (CBO) projections (March 2006 CBO baseline). SCHIP is State Children's Health Insurance Program. LTC is long-term care. DSH is disproportionate-share hospital.

government would be \$25.5 billion and to states, \$12.6 billion. Lowering the SCHIP matching rate would save the federal government \$0.7 billion and increase state costs by the same amount. The matching rate increases would shift \$14.8 billion from the federal government to the states. Option 2 would federalize Medicare acute

care services for drugs and eliminate the current clawback payments; this would raise federal outlays by \$14.1 billion and give comparable savings to states. Eliminating DSH payments would save the federal government \$9.1 billion.

■ **Option 3.** Option 3 would increase federal spending by \$41.1 billion while reducing state expenditures by \$15.3 billion. Coverage would be expanded to 100 percent of poverty, and matching rates for acute care services would be unchanged. The primary intent of this option is to help states with the growing threat of long-term care spending by increasing matching rates 30 percent. Because the coverage expansion would be less extensive, DSH payments would be retained but restructured. The coverage expansion with no change in federal matching payments would cost the federal government \$14 billion and would cost states \$10 billion. Federalizing the acute care for dual eligibles would shift another \$14.1 billion from the states to the federal government. Federal long-term care spending would increase \$13 billion; state spending would fall the same amount. The DSH restructuring would result in a net state spending increase of \$1.9 billion.

■ **Option 4.** Option 4 would raise federal spending by \$48.7 billion while reducing state spending by \$22.8 billion. The major focus of this option is to federalize all care for dual eligibles, including long-term care. It would also shift to states the responsibility for long-term care for non-dual eligibles. Again the coverage expansion to 100 percent of poverty would increase federal outlays by \$14 billion and state outlays by \$10 billion. Federalizing all care for dual eligibles would shift \$47.9 billion from the states to the federal government. Shifting responsibility to states for long-term care for non-dual eligibles would save the federal government \$13.2 billion and increase state spending by the same amount.

## Results: Regional Impacts

We next show the effects on coverage and spending by region; we do not provide the detail on changes for each option by region in the interest of space. We estimated that for an expansion to 100 percent of poverty, 3.1 million of the 7.1 million increase in Medicaid enrollment would come from the South, as would 4.7 million of the 11.1 million increase if the expansion were to 150 percent of poverty. As a result, the South would have the largest increases in both federal and state spending from the mandated coverage expansion. The increases in federal matching rates would help the Northeast the most because Medicaid programs in that region tend to have broader coverage and rich benefits. Federalizing spending for the dual eligibles also would help the Northeast the most, again because of broad coverage and rich benefits, particularly long-term care. Cuts in DSH payments would hurt the Northeast and South the most. DSH restructuring would have adverse effects on the Northeast but would benefit all other regions (although not all states within those regions). Shifting long-term care services for non-dual eligibles back to the states would have the greatest effect on federal outlays in the Northeast and West.

These effects can be shown most clearly by comparing the Northeast and the South (Exhibit 3). As we move from Option 1 to Option 4, the effect of the coverage expansions is reduced, and the impact of federalizing current spending for dual eligibles is greater. Further, as we move from Option 1 to Option 4, the emphasis on acute care declines and that on long-term care increases. The result is that federal outlays would increase far more in the Northeast in Option 4 than in Option 1. Similarly, the savings to northeastern states would be much greater in Option 4 than in Option 1. The Northeast would benefit the most from Option 4 because it has broader coverage and richer benefits and more spending on dual eligibles. In the South, the opposite is true. The South would benefit the most from Option 1 primarily because of the coverage expansion and benefits; it would benefit least from Option 4 because of more limited coverage and benefits. The effects on the Midwest and West are somewhat similar to the pattern seen in the Northeast, but to a lesser degree; that is, the increase in federal spending would be higher in Option 4 than in Option 1, and savings to the states would be greater in Option 4 than in Option 1.

### Other Issues

A number of other issues are germane to serious reform; none of these were included in the models described above or the cost estimates, but they merit consideration nonetheless.

■ **Cost containment policy.** Medicaid cost containment policy needs to be redirected. Cost control efforts have primarily been focused on limitations on benefits and on provider reimbursement rates and, more recently, on the use of managed care,

**EXHIBIT 3**  
**Impacts Of Proposed Medicaid Reform Options, By Region, Billions Of Dollars And Percent Change, 2006**

| Option | Change in Medicaid spending (\$)    |       |         |       |         |       |         |       |       |
|--------|-------------------------------------|-------|---------|-------|---------|-------|---------|-------|-------|
|        | Northeast                           |       | Midwest |       | South   |       | West    |       |       |
|        | Federal                             | State | Federal | State | Federal | State | Federal | State |       |
| 1      | 9.6                                 | -6.9  | 8.9     | -3.0  | 16.9    | -3.2  | 9.4     | -2.0  |       |
| 2      | 9.8                                 | -7.4  | 9.2     | -3.5  | 15.9    | -1.8  | 9.9     | -2.9  |       |
| 3      | 10.2                                | -8.1  | 8.9     | -3.3  | 13.9    | -2.0  | 8.1     | -1.8  |       |
| 4      | 14.7                                | -12.6 | 10.9    | -5.3  | 12.8    | -0.9  | 10.1    | -3.8  |       |
| Option | Percent change in Medicaid spending |       |         |       |         |       |         |       |       |
|        | 1                                   | 22.1  | -16.8   | 28.4  | -12.6   | 35.8  | -11.7   | 34.0  | -8.8  |
|        | 2                                   | 22.5  | -18.0   | 29.5  | -14.7   | 33.7  | -6.6    | 35.9  | -12.8 |
|        | 3                                   | 23.4  | -19.8   | 28.4  | -13.9   | 29.4  | -7.3    | 29.3  | -7.9  |
|        | 4                                   | 33.8  | -30.7   | 34.8  | -22.3   | 27.1  | -3.3    | 36.3  | -16.7 |

**SOURCES:** Authors' calculations based on population information from the March 2005 Current Population Survey and spending data from the 2002 Medicaid Management Information System (MMIS).

**NOTE:** Spending data were adjusted to 2006 using the CMS-64 and Congressional Budget Office (CBO) projections (March 2006 CBO baseline).

primarily for Medicaid's lowest-cost enrollees. About 7.6 percent of Medicaid enrollees account for about two-thirds of Medicaid spending.<sup>19</sup> Almost all high-cost enrollees are elderly (49 percent) or disabled (43 percent). A majority of these are dual eligibles. Concerted efforts need to be made to manage the care and control the costs of these high-cost populations.<sup>20</sup>

Policies could include high-cost case management programs, changes in payment approaches to provide incentives for physicians to coordinate and manage the care of patients with multiple chronic conditions, the expansion of Medicaid managed care (with beneficiary protections) to more of the disabled, and partial capitation arrangements with all-inclusive rates for case management and primary care services with additional payments for specialist and hospital care.<sup>21</sup>

There is still much to be learned about effective methods of controlling costs and improving outcomes for these enrollees.<sup>22</sup> What is clear is that the federal government should make a sizable investment in promoting demonstrations, learning what works, and helping spread successful models.

■ **Improving provider payment rates.** Medicaid reimbursement policy should be reformed with the federal government setting minimum standards and rates. Setting minimum Medicaid rates, for example, could be the responsibility of the Medicare Payment Advisory Commission (MedPAC). Medicaid rates could be gradually increased over time to, say, a minimum of 90 percent of Medicare rates. Increases in Medicaid payment rates—in particular, to physicians and hospitals—could do much to improve Medicaid's image in the provider community.

■ **Creative financing.** The federal government in the past few years has been aggressive at reducing the use of DSH and supplemental payment programs that have been financed through provider taxes and IGTs, but states are continuing to develop UPL programs and using other benefits such as targeted case management and school-based clinics to generate federal payments in similar ways.<sup>23</sup> These programs added at least \$13.0 billion to federal outlays in 2005 with only partial state matching contributions. The federal government should clarify and then uniformly enforce current rules designed to reduce or eliminate all practices that generate federal dollars without real state contributions.<sup>24</sup>

■ **Increasing Medicaid participation rates.** There should be a major federal effort to increase participation in Medicaid by those who are eligible but uninsured. Lessons learned from states such as Massachusetts that have achieved high participation rates should be applied in all states.<sup>25</sup> There should be a combination of federal promotion and advertising as well as federal standards for outreach, income verification, recertification, and so forth. Higher participation would increase Medicaid enrollment and government spending but also reduce the number of uninsured Americans.

■ **Reforming spend-down requirements.** The current spend-down provisions for acute care in Medicaid require people to potentially spend a considerable amount of their income and assets before becoming eligible for Medicaid.<sup>26</sup> Medic-

aid operates as a catastrophic plan with a potentially huge deductible, essentially requiring people to deplete virtually all of their resources. We believe that this should be reformed by requiring people to spend down to the income eligibility standard (100 or 150 percent of poverty) or to spend 15 percent of their income, whichever is less. If this provision were limited to acute care services and to those below 300 percent of poverty, it would cost about \$6.0 billion.<sup>27</sup>

■ **Medicare's two-year waiting period.** Eliminating the current two-year waiting period for Medicare benefits for Social Security Disability Insurance (SSDI) beneficiaries should be explored. This population could be made eligible for Medicare immediately. This would assure uniformity of benefits and also provide additional fiscal relief to states. Stacy Dale and colleagues have estimated that the Medicaid savings from eliminating the waiting period would be \$5.6 billion in 2002 dollars; adjusted for inflation, this would increase to \$7.5 billion in 2006.<sup>28</sup>

■ **Long-term care.** Reform of public financing of long-term care is generally beyond the scope of this paper.<sup>29</sup> Two areas, however, strike us as particularly important. First, efforts to limit large transfers of assets to obtain Medicaid eligibility are clearly appropriate, although they are not likely to result in sizable budget savings.<sup>30</sup> But, more importantly, current spend-down requirements for institutional care result in the near-impovery of residents before they become eligible. There should be changes in these requirements for institutional care permitting people to retain higher levels of assets and income. The second is the extreme unevenness in coverage of home and community-based services (and resulting unmet needs) for impaired elderly and disabled people. The new option in the DRA to convert such services from waivers to optional services could be made mandatory along with increasing the income threshold and expanding the list of services covered.

■ **Federal matching rates.** The federal matching formula should be reformed.<sup>31</sup> The current system is essentially based on relative per capita income. A measure that captures both income and the share of the population below 200 percent of poverty better reflects states' needs. Switching to such a measure would provide additional assistance to states such as New York and California that have very uneven distributions of income and would reduce matching rates in states with more equal income distributions. If these changes were adopted along with other policies described above, there would still be increases in federal matching payments in the latter states. Further, some way of adjusting federal matching rates in periods of economic downturn should be adopted—that is, matching rates would rise if unemployment rates increased.

## Concluding Comments

The reforms we have discussed in this paper would go a long way toward solidifying the system of financing care for low-income Americans. They would simplify Medicaid's structure, expand coverage for low-income populations, and largely eliminate the financial manipulations that have plagued the program in recent

years. They would shift more financial responsibilities to the federal government, which has far superior taxing and borrowing capabilities, and thus provide fiscal relief to states.

Both the expansion and the greater uniformity of coverage for low-income populations would provide a base that could be built upon. Many observers have argued for a combination of Medicaid expansions and tax credits or income-related subsidies for expanding coverage.<sup>32</sup> Indeed, such a structure was recently enacted in Massachusetts. Our approach would allow the nation to take even further steps to reduce the large number of uninsured people.

We recognize that the nation faces a large structural deficit well into the future and that an expansion of a major entitlement program is not likely to be politically feasible in the near term. But any effort to expand health insurance coverage faces the same obstacle. The question is whether the fiscal straitjacket that has been the outcome of recent federal tax and spending policies should foreclose debate over tackling such major national problems.

The proposals that we have laid forth would certainly increase federal spending; however, the cost containment policies we have discussed should lower the rate of growth below current projections. But the higher spending estimates should also be put in perspective. In the four models we described, federal spending would increase, but state spending would decline. The net effect of \$26–\$30 billion annually is clearly an overstatement because the reductions in the number of uninsured people would reduce the federal, state, and local costs of supporting the safety net, and increased Medicaid enrollment would reduce some costs for employers and individuals as well.

**M**EDICAID REFORM IS AN IMPORTANT PRIORITY. The cost pressures Medicaid places on state governments often affects their ability to adequately address other priorities. Funding pressures also cause states to reduce Medicaid benefits and provider payment rates, particularly in times of fiscal stress. At the same time, states' reluctance to expand coverage to levels that are allowed by federal law is contributing to the high number of (and growth in) uninsured Americans.

We have also argued that Medicaid reform can and should address the growth in program costs. Proposals that would reduce benefits or have low-income people pay more at the point of service will have at best a small effect on costs but could also have harmful effects. Serious attempts at containing costs in Medicaid as well as Medicare can only come from concerted efforts to reduce the cost of the chronically ill patients who account for the bulk of health care spending. Programs to improve the efficiency by which these patients are cared for are in their infancy. But the long-run cost problems that the Medicare and Medicaid programs face can only be solved when we understand better how to efficiently and effectively care for these populations.

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## NOTES

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