MEDICAID; A THOUGHTFUL PLAN OF REVISION

June 7, 2017

Background

In 2017 the desire to reform Medicaid became a central part of the Republican agenda to "Repeal and Replace Obamacare" (i.e., the ACA). Of particular concern to those seeking reform is the cost of this federal entitlement program, the growth in its spending, and the impact that these costs have on the national debt.

Medicaid was created as part of Title XIX of the Social Security Act of 1965. The program created a unique federal approach to entitlements in that the funding for the plan was divided between the federal government and the states. This program provides for health and long-term care for low-income Americans. Medicaid has several components: aid for those on TANF (welfare for women with dependent children); coverage for those who are disabled; low income Medicare recipients; and children (the Child Health Plan or CHP).

The Kaiser Family Foundation's report in 2016 revealed that federal Medicaid spending was $348 billion. In addition, states spend an additional $204 Billion under the Federal Medical Assistance Percentage ("FMAP") formula. Total covered lives in the United States was 69 million people in 2015. This total ($553 Billion) is comparable to national defense spending ($598Billion in 2015). These amounts do not include the cost of administration for this program, these costs are only for the cost of care. The cost of administration is provided for under a separate formula.

Beginning in 2014, the ACA established enhanced FMAPs for the cost of services to low-income adults with incomes up to 138% of the federal poverty level who were not covered otherwise. The cost of the 2010 Medicaid expansion is estimated to be $1 Billion.

In Colorado, federal expenditures were $4 Billion, with an additional $3 Billion spent by the state.

Given the magnitude of this spending, it is important to note the fundamental inequity and opportunity in a system where spending per enrolled beneficiary varies widely from state to state. This is because the current system bases future spending on the state's per capita income and historical spending patterns. The result is that some states, who have been more liberal in their Medicaid spending, receive a significantly higher amount per beneficiary than others. For instance, in 2011 (most recent figures available) Massachusetts' allocation per beneficiary was more than $11 thousand and New York's per capita amount was more than $10 thousand. Meanwhile, states with more frugal approaches received dramatically less: e.g., Maine was $6,761 and Colorado was $5,730 per enrolled beneficiary.

At the same time, federal regulatory oversight applied to all states. Simply equalizing federal spending to a level 10% higher than the more efficient stats (like Maine or Colorado) could generate significant savings.

Issues to be considered

There are several issues that could also be addressed as Medicaid is reassessed. These are listed below.

The Kaiser Family Foundations 2015 report on Medicaid noted that "the state FMAP formula has been basically unchanged since its enactment, in 1965, when Lyndon Johnson was President. The variable in the formula (per capita income) has two major shortcomings. First, incredibly, it does not adequately measure a state's population in poverty and the cost of serving that population, not does it adequately measure the total resources available within each state to finance health and long-term care for the low-income populations. Second, the formula does not adjust quickly for economic downturns, which is critical since Medicaid enrollment is counter-cyclical; when unemployment increases in an economic downturn, state revenues fall but more residents access health care through Medicaid."

Any attempt to "lock in" payment levels in order to protect the federal treasury needs to first reset the base rates per beneficiary so that states that have historically been wise stewards are not penalized while those with more generous programs lock in payments at higher levels.

Of particular note is the fact that US Medicaid expenditures grew by 9.2% in 2009 (latest available growth statistics). This growth rate is projected to continue, unless structural changes are created.

Finally, the ACA's expansion of the eligible population provided payments based upon revised FMAP rates (100% through 2016, then 90% by 2020. This dramatic change in matching funds caused states to decide whether to expand their state Medicaid for those with incomes up to 138% of federal poverty, and the increased spending was charged to the federal treasury.

Reforms

This paper seeks to promote a discussion regarding the future of Medicaid and to propose ideas that will make this important program sustainable, over time.

1. **State Flexibility**
   The old axiom that "health care is local" has been proven by multiple studies over the years. That being the case, states should be given the maximum flexibility in devising a structure for Medicaid that best suits their local conditions. The federal government's role must then shift to only managing the cost- not the detailed operation- of the overall program. States should have authority to structure their program as they see fit.

2. **Revised payment formulas**
   States should be given the choice of whether to select payments based upon a per

capita (actually a per beneficiary) amount or a block grant. In any event, the formula must begin with a base line equivalent to 2016 national expenditures. In order to avoid chaos at the state level, this shift must be phased in over at least five years.

As part of this change, payment amounts per state should be restructured to consider things such as each state's total resources available to finance care, and the size of each state's poverty population. Furthermore, a supplemental fund should be created to provide additional reimbursements to states who have high beneficiary satisfaction scores, and demonstrate the ability to create innovative programs that save cost over time.

Once the formula is established for payment, annual escalation must be included based upon the rise in the cost of health care (medical portion of CPI), changes in enrollment, and special circumstances such as significant economic events (e.g., a recession), unemployment trends in each state, and any natural disasters that may have impacted the demand for greater enrollment.

Changing the formulaic approach to payments should not be viewed as a short-term financial fix for the national debt but rather a more rational basis for payment, over the long term.

3. **Plan Revisions**

Children represent approximately 80% of the Medicaid recipients but only 20% of the cost. Furthermore, the CHP program has demonstrated that the needs of children are different than are those of adults. For this reason, it is proposed that the children's portion of Medicaid be carved out and the protections currently in-place be preserved.

Expansion states should be allowed to retain their expansion populations if they desire, but the FMAP will phase-out (currently 90%) so that the standard FMAP percentage will apply to this population starting in 2025.