MEDICAID Improvement and State Empowerment Act

About Medicaid

The Medicaid program was created in 1965 for the purpose of providing medical assistance to low-income Americans, particularly children, through a shared state-federal commitment. Today, Medicaid is an entitlement program that finances medical care, as well as long-term care, for more than 68 million people in FY2010. The estimated annual cost to American taxpayers for this program was roughly $381 billion in FY2009.[1] Each state administers its own version of Medicaid under federal rules.

Medicaid Status Quo Unacceptable for Patients

Medicaid was intended to serve as a targeted safety-net for very low-income Americans in need of necessary medical care. But over the years, the program has lost its way. Today, Medicaid's intended safety net is fraying under the weight of unaffordable Washington mandates, which are jeopardizing the access and quality of care provided through Medicaid. According to the independent committee that advises the Centers for Medicare and Medicaid Services (CMS) on payment decisions, Medicaid reimbursement rates have resulted in 40 percent of physicians restricting access to patients in the program.[2] And the physicians that do offer care find it difficult to get patients access to specialized care or timely interventions. Medicaid patients often end up in the emergency room for basic health services simply because they cannot get access to a primary care physician. In fact, Medicaid patients use the ERs more than the uninsured.[3]

The lack of access has resulted in poor patient outcomes in the Medicaid program relative to patients in private plans. Sadly, there is growing documentation of this disparity[4], so much so that some have demonstrated that being enrolled in Medicaid is actually worse than having no health coverage at all.[5]

Medicaid Status Quo Unaffordable for Taxpayers

Since 1965, the program has expanded to levels that are unsustainable for patients, states, and taxpayers. Today, nearly one in four Americans is on Medicaid.[6] Unfortunately, the new health reform law makes mandatory changes to the program, enrolling an estimated 18 million individuals into the program, according to the Congressional Budget Office. Current Medicaid cost projections are staggering: over the next 10 years, the federal government is projected to spend more than $4 trillion on Medicaid.[7] Independent experts and analysts have repeatedly warned that Federal health care spending, which includes Medicaid, is our nation's primary budgetary and economic challenge over the long-run.[8]

States are actively grappling with difficult budget situations in the face of a collective $175 billion budget shortfall through 2013.[9] Because Medicaid is funded by both the federal and state governments, expanding the program dramatically increases costs for states. Former Governor Phil Bredesen (D-TN) said that he worried that the expansion of Medicaid was "the mother of all unfunded mandates" for states.[10] Unfortunately, the Governors' fears regarding "unfunded mandates" are coming to pass—a tally of nonpartisans' estimates suggests that the new unfunded mandates in the health care law will cost states at least $118 billion or more.[11] This costly expansion, as well as a host of other

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[1] Herz, Elicia J. "Medicaid: A Primer," a Report for Congress, Congressional Research Service, July 15, 2010, RL33202. http://aging.senate.gov/crs/medicaid1.pdf
[2] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *Wall Street Journal*. January 9, 2009, http://online.wsj.com/article/SB123137487987962873.html.
[3] Marcus, Mary Brophy, "Study: Uninsured don't go to the ER more than insured," *USA Today*. May 19, 2010, http://usat.ly/kCcxO3
[4] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*. January 9, 2009, http://online.wsj.com/article/SB123137487987962873.html.
[5] Gottlieb, Scott, "Medicaid Is Worse Than No Coverage at All," The Wall Street Journal. March 10, 2011, http://online.wsj.com/article/SB10001424052748704758904576188280858303612.html.

[6] Congressional Budget Office, "Spending and Enrollment Detail for CBO's August 2010 Baseline: Medicaid," www.cbo.gov/budget/factsheets/2010d/MedicaidAugust2010FactSheet.pdf
[7] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011. www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf
[8] The National Commission On Fiscal Responsibility And Reform, "The Moment of Truth," December 2010. http://goo.gl/K8F2m. Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010. www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf
[9] National Governors' Association, January 24, 2011 letter to Congress, http://bit.ly/fSOfwa
[10] Sack, Kevin, and Pear, Robert. "Governors Fear Medicaid Costs in Health Plan," The New York Times, July 19, 2009. http://goo.gl/jRMbz
[11] Hatch, Sen. Orrin, and Upton, Chairman Fred. "Medicaid Expansion In The New Health Law: Costs To The States," 2011. http://1.usa.gov/eMbmHj

mandates, shifts billions of dollars of costs onto state taxpayers, leaving states stuck holding the tab and patients feeling the clinical consequences.

Not only is the cost of Medicaid untenable for taxpayers, but the current system has been gamed, even exploited. While the current Medicaid funding scheme was designed to reflect relative state income levels and cost of living, some states use a variety of taxes, fees, and other budget gimmicks to rake in federal dollars, leaving other states with less. Consider as an example 2006 federal Medicaid expenditures per patient, which varied from $1,679 in Nevada to $6,340 in New York.[12]

States Need More Flexibility, Fewer Mandates

States have repeatedly demonstrated they can achieve real success on behalf of patients when empowered with the flexibility they need to innovate and improve their Medicaid programs. When freed from Washington's red tape and mandates, states can improve patient outcomes and decrease costs. States have utilized Medicaid waivers to demonstrate the ability to improve care and return savings, such as Rhode Island's Global Consumer Choice Demonstration, which provides a capped federal allotment for Medicaid over five years, and Community Care of North Carolina, a provider-led medical home reform that has increased access to primary care, decreased emergency department usage, and saved money.

Medicaid Must be Reformed, Restoring The Program to Its Original Mission

The Medicaid program is broken. Today in America some of the poorest and sickest among us may suffer the most, while politicians and bureaucrats call for more regulation and more spending. But more of the same does not make sense. We believe Congress has the opportunity to respond to states demands for flexibility and predictability, while putting this targeted safety-net program on a sustainable path for taxpayers. We can improve Medicaid by returning to the program's original purpose: a limited, state-managed safety-net program to meet the health care needs of the poorest and neediest among us.

Much work remains to be done to reform our nation's health care system in a meaningful manner that achieves the goal of ensuring that every American has access to quality and affordable health care. Reforming Medicaid is the first step in reforming health care and putting our nation's fiscal house back in order. The Medicaid Improvement and State Empowerment Act of 2011 will empower states with the programmatic flexibility and financial predictability that they need to strengthen and improve their programs on behalf of their patients by:

- **Transitioning from a flawed and unsustainable FMAP model.** The current open-ended entitlement nature of Medicaid is bankrupting federal and state budgets, while perpetuating inequities advanced by the well-connected. The time has come to transition to taxpayer-provided pass-through health grants to provide or facilitate medical assistance for low-income, uninsured individuals.
- **Providing predictability to long-term care services.** Unlike health coverage for acute medical care costs, long-term care services and costs are much more predictable and do not grow at the rate of medical inflation. States will be able to better plan for and manage their patients long-term care needs through taxpayer-provided pass-through grants.
- **Freeing States from the unaffordable and unsustainable mandates in the Health Care Law and Stimulus.** States know their patients better than the Federal government. Instead of Washington dictating how states must run their programs, states will have complete flexibility to design the health care and coverage that will work for their patients and pocketbooks. No longer will states have to ask permission from Federal bureaucrats before advancing innovative reforms that will improve outcomes and decrease costs.
- **Preserving Medicaid acute care for aged individuals and individuals with disabilities.** The bill maintains acute care for individuals with disabilities and "dual eligibles" to ensure benefit security and stable funding for these most vulnerable patients.
- **Incentivizing States to advance medical malpractice reform.** Some of the savings from this Act's reforms will be granted to states which have achieved meaningful malpractice reforms that reduce care costs.

[12] Robert B. Helms, Testimony before U.S. House Energy and Commerce Committee, July 22, 2008. http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.072208.Helms-Testimony.pdf.