Threading the Needle — Medicaid and the 113th Congress

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Medicaid is a veteran of decades of warfare over its size and cost. Nevertheless, the program now plays a vital role in the U.S. health care system and a foundational role in health care reform. The central question, as we approach a major debate over U.S. spending and federal deficits, is how to preserve this role and shield Medicaid from crippling spending reductions.

On paper, Medicaid enjoys a relatively protected position in the budget debate. The Budget Control Act, which provides the initial framework for this debate, insulates Medicaid from sequestration, the process of deep and automatic spending reductions that are set to occur if Congress and the President fail to reach a compromise in order to avoid the "fiscal cliff" — a task that has taken on greater urgency in the face of a new Congressional Budget Office (CBO) report detailing the adverse economic effect of going over the cliff.[1]

But in reality, Medicaid is not expected to hold onto its protections. Health care spending is viewed as a principal driver of the long-term federal deficit. Both Democrats and Republicans are committed to curbing the rate of growth of federal spending on health care, albeit through dramatically different approaches, with Democrats emphasizing transformation of the health care system through payment reform and organizational restructuring and Republicans favoring tougher limits on federal spending that might galvanize deep downstream changes on the part of health care providers and consumers. Budgetary protections for Medicaid date to the 1980s, but today's politics are less tolerant of programs for poor and vulnerable populations. Medicaid is also at a deep political disadvantage. Medicare (similarly, although less completely, protected under the Budget Control Act) enjoys greater political protection, as do the hundreds of billions of dollars in forgone tax revenue on employer-sponsored health insurance.

It's hardly surprising that policymakers would focus on this largest of all means-tested entitlement programs as a possible source of federal savings. Medicaid is unequaled among federal grant programs: more than 60 million children and adults rely on the program, and it's projected to grow to 80 million beneficiaries by 2020 if all states adopt the eligibility expansion in the Affordable Care Act (ACA). But Medicaid beneficiaries lack political clout. Naturally, lawmakers desperately desire to avoid politically unpopular revenue increases or deep spending reductions in federal programs. In such an overheated environment, Medicaid could easily emerge as a poster child for getting serious about entitlement spending. Just how big a hit Medicaid could take might become clear by the end of 2012 if the President and Congress reach agreement on the contours of a budget blueprint to replace sequestration and tax increases.

The problem is that Medicaid's cost is driven by high enrollment, not excessive per capita spending.[2] As a result, there's very little money to wring out of Medicaid without shaking its structure in ways that reduce basic coverage. Medicaid is part of the base on which health care reform rests; if it is not expanded per the ACA, the nation will lose its chance at near-universal health insurance coverage, which is essential to achieving systemwide savings and halting a $50 billion annual cost shift to insurers and patients. Deep federal spending reductions could lead states to abandon Medicaid expansion as a result of a confluence of factors — the still-fragile nature of many state economies, the continuing ideological opposition to Medicaid expansion, and the Supreme Court decision to permit states to opt out of such expansion altogether.

Medicaid is indeed large. But considerable evidence shows its effectiveness: most recently, a study by Sommers et al. documented its positive effects on health and health care.[3] Experts in Medicaid spending also acknowledge the program's operational efficiencies, achieved by states through the aggressive use of managed care and strict controls on spending for long-term care. Much of the health care that Medicaid beneficiaries receive is furnished through safety-net providers such as community health centers, which are highly efficient and accustomed to operating on tight budgets with only limited access to costly specialty care.[4] Furthermore, Medicaid's physician payments are substantially lower than those from commercial insurers and Medicare — a disparity that unfortunately limits provider participation even as it helps to keep

per capita spending low. Indeed, the CBO has found that insuring the poor through Medicaid will cost 50% less per capita than doing so through tax-subsidized private insurance plans offered through state health insurance exchanges.[5]

Proposals to significantly reduce federal Medicaid spending pose a range of problems. By far the most harmful, in my view, would be the two-pronged approach advanced by the House Budget Committee under the chairmanship of Congressman Paul Ryan (R-WI): repealing the ACA's Medicaid expansion and turning the underlying program into block grants, thereby achieving nearly $2 trillion in federal savings over 10 years. Elevated poverty rates and recent and ongoing demographic shifts argue against setting an arbitrary limit on federal Medicaid spending because of the presumed effect on program enrollment. And recent tragedies, such as Hurricane Sandy, underscore the way in which uncontrollable events can cause unexpected surges in the need for government assistance.

Other proposed cost-cutting measures would be viewed as regressive shifts in policy if they didn't offer alternatives to a block-grant program. One approach might be to tighten the formula determining the amount of federal payments to states. Such an approach, even if accompanied by relaxed rules governing coverage and patient protections, would simply expose states to the high cost of health care while abandoning millions of patients.

Another proposal would impose a per capita limit on federal spending. This approach would avoid some problematic results of an across-the-board payment cap, since it would allow the Medicaid population to grow. But it would be difficult to administer and unfair to states with historically low per capita spending. It would also require constant adjustment in order to align payments with the actual beneficiaries served, since higher payments would be needed for higher-cost beneficiaries. In addition, without extensive adjustments to reflect differences in the current scope of state programs and in health care costs, a per capita cap could force low-spending states to slash benefits and services, impair all states' efforts to improve benefit and payment levels, and exacerbate states' resistance to the 2014 expansion.

Other proposals would place additional limits on the states' ability to generate their share of Medicaid spending, making it harder for them to qualify for federal payments. One proposal would place new restrictions on states' use of taxes on health care providers, such as hospitals, nursing homes, and pharmacies, to help fund Medicaid, although user fees are a common approach to financing governmental programs. Another would limit states' ability to count toward their total Medicaid spending local financial investments in public hospitals and health care systems that are apportioned between Medicaid and general support for care of indigent patients. Medicaid has historically rested on states' ability to apportion their health investments in this manner; changing the rules would destabilize these institutions at the very time when expanded insurance coverage is creating greater demand for care.

The essential task is to thread the needle by accelerating efficiency reforms in health care payment and organization that, in turn, can generate savings over time while not damaging Medicaid's role as a pillar of health care reform. Of particular importance is a heightened focus, begun under the ACA, on reforms that emphasize community care for millions of severely disabled children and adults, including patients who are dually enrolled in Medicare and Medicaid and who rely heavily on long-term institutional care. This is the time for delicate and careful strategies to gradually slow Medicaid growth rates, not for blunt-force strategies that simply slash federal financing and cripple Medicaid at a pivotal juncture in its evolution.

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