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RESEARCH SUMMARY

The Economics of Medicaid: Assessing the Costs and Consequences

March 2014

Medicaid is the largest health insurance provider in the United States. Under the Affordable Care Act (ACA), the Congressional Budget Office (CBO) projects Medicaid enrollment to increase nearly 30 percent by 2024 and federal spending on the program to double over the next decade. For the states, Medicaid is already the largest single budget item, and its rapid growth threatens to further crowd out other spending priorities.

In a book forthcoming from the Mercatus Center at George Mason University, nine experts discuss the escalating costs and consequences of a program that provides second-class health care at first-class costs. The book begins with an explanation of Medicaid's complex state-federal–funding structure. The authors then examine how the system's conflicting incentives discourage both cost savings and efficient care. The final chapters address the pros and cons of the most popular Medicaid reform proposals and offer alternative solutions.

This book gives a timely assessment of how Medicaid works, its most problematic components, and how—or if—its current structure can be adequately reformed to provide quality care at sustainable costs for those in need. A brief review of Medicaid's key challenges, followed by an overview of each chapter, is below. To read the book in its entirety and learn more about the authors, please visit www.economicsofmedicaid.com.

Medicaid Key Challenges

Rapid Growth Worsens Fiscal Strain

- CBO projects Medicaid enrollment to increase nearly 30 percent by 2021 and federal Medicaid spending to double over the next decade.
- Medicaid is already states' largest single budget item, and its rapid growth threatens to further crowd out other spending priorities.

Funding Structure Fundamentally Flawed

- Medicaid's complex state-federal structure creates conflicting incentives that discourage cost savings and efficient care by creating tension and distrust among federal and state governments, health care providers, and patients.

Second-Class Care, First-Class Costs

- Medicaid's low physician-reimbursement rates coupled with high administrative requirements deter physicians from accepting Medicaid patients.
- For Medicaid beneficiaries, this leads to poorer access and poorer health outcomes—including delayed diagnosis and treatment, a greater reliance on emergency rooms, and higher mortality rates—than those with either private insurance or Medicare.

No Easy Fixes

- Even the most popular reform proposals will fail to provide a comprehensive solution to Medicaid's problems. While there is no panacea, there is a consensus among the authors that any substantial improvement will require changing the incentives inherent in Medicaid financing.

Chapter Summaries

The Structure of Medicaid
Joseph Antos, resident fellow, American Enterprise Institute

Medicaid's structure creates a dynamic among the states, the federal government, and medical practitioners that reduces incentives for cost savings and efficient care.

Medicaid, the primary means of financing health care for America's poor, is a complex system operated by each state and jointly financed with the federal government under a matching arrangement. Federal funding covers a minimum of half of each state's Medicaid costs, but this figure can be much higher depending on a state's Federal Medical Assistance Percentages (or FMAP)—a formula based largely on per capita income.

Antos explains that while extensive federal regulations and requirements limit states' flexibility in administering Medicaid, the federal matching grant provides an enormous incentive for states' ever-expanding participation in the program. On average, states pay only 43 cents for every Medicaid dollar spent. Medicaid's minimum 50-percent match rate encourages even the wealthiest states to offer more generous plans than their needier counterparts (if not for the match-rate minimum, some high-income states would receive a federal match as low as 23 percent).

Antos also explains why states have little incentive to contain Medicaid costs. Because the federal government shares these costs, it also shares savings. Thus, to save one dollar, a state must cut at least two dollars from its operating budget (for poorer states with higher matching rates, this figure is commensurately higher). The ACA Medicaid expansion's initial provision of full coverage for newly eligible populations will further reduce states' incentives to contain costs. States will also continue to seek out federal programs and loopholes that allow them to claim higher matching payments.

On average, Medicaid pays providers more than 40 percent less than private insurers for similar procedures. The poor reimbursement rate—combined with heavy administrative and cost burdens—greatly reduce providers' incentives to accept Medicaid patients. For Medicaid beneficiaries, this leads to poorer access and poorer health outcomes—including delayed diagnosis and treatment, a greater reliance on emergency rooms, and higher mortality rates—than found for those with private insurance, Medicare, or in some cases, no coverage at all.

Medicaid's Cost Drivers
June O'Neill, former director, Congressional Budget Office

Understanding Medicaid's cost growth requires understanding its key drivers: benefit expansion, liberalization of eligibility rules, rising enrollment of high-cost recipients, and waste, fraud, and abuse.

While Medicaid costs have grown with the increase in eligible participants, the composition of the Medicaid population has shifted.

O'Neill notes that while the number of children and working-age adults receiving benefits has rapidly increased to almost three-fourths of total beneficiaries, these groups incur relatively low per capita medical costs, and thus account for only one-third of total Medicaid expenditures. The participation of the higher-cost elderly beneficiaries has plunged as their use of nursing homes has declined, sharply reducing their share of total Medicaid spending. Meanwhile, the number of disabled beneficiaries, who also

employ high-cost services, has grown rapidly, spurred by increases in the population receiving Supplemental Security Income benefits.

In the future, the ACA's Medicaid expansion will further challenge cost control, especially if it draws high-cost population groups. Further long-term cost pressures will arise as the population ages into their eighties and nineties, making nursing home use more likely. Medicaid expenditures are also affected by the usual forces that impact medical costs: changes in the broader economy, health care provider prices, and programmatic changes at the state or federal level such as terms of eligibility and covered services.

O'Neill further examines the overall government health care cost escalation due to factors such as the rise in "dual eligibles" able to enroll in both Medicare and Medicaid, and the impact of waste, fraud, and abuse that has boosted costs dramatically.

Medicaid: The Federal Side of the Budget Equation
Jason J. Fichtner, senior research fellow at the Mercatus Center at George Mason University

While the ACA significantly expanded Medicaid's beneficiaries and costs, it failed to address the program's fundamental flaws that produce conflicting incentives, high costs, and poor health care.

Medicaid is today the largest health insurance provider in the United States, with about 69 million people enrolled in 2013; the Congressional Budget Office (CBO) projects this number to increase by about 30 percent by 2024 under the ACA. The CBO also projects federal Medicaid spending to more than double over the next decade. But this estimate is dependent on several factors, including how many and which states choose to expand Medicaid, and to what extent ACA Medicaid enrollment projections may be exceeded.

Fichtner walks through the basics of Medicaid's shared federal-state financing and discusses the myriad factors responsible for Medicaid's rapid cost acceleration over the years. He then looks to the estimated and potential increases in future federal Medicaid costs under the ACA's eligibility expansion. He concludes that significant structural reform of the Medicaid program is needed to prevent dire repercussions for both the federal budget and the US economy at large.

The State Side of the Budget Equation
Nina Owcharenko, director of the Center for Health Policy Studies, the Heritage Foundation

Medicaid costs will eventually crowd out states' ability to pay for other government services.

Medicaid is the single largest item in most state budgets, accounting for an average of about 24 percent of all state spending—more than elementary and secondary education. This spending is expected to climb in the future due to increased enrollment, largely as a result of the ACA's Medicaid expansion and the increasing costs of providing medical services.

Owcharenko reviews popular means states employ to control spending, including adjusting reimbursement rates for providers, restricting eligibility and enrollment, limiting benefits and services, and adopting care-management tools, such as managed care. Some states have also recommended structural financing changes, such as block grants, as means to better control costs over the long term.

Owcharenko also considers the various techniques states employ to increase the flow of federal Medicaid dollars into their state, including eligibility and benefit expansions.

Changes to Medicaid under the Affordable Care Act
Charles P. Blahous, senior research fellow at the Mercatus Center at George Mason University and public trustee for Medicare and Social Security

The ACA will significantly increase future Medicaid expenditures for both the federal government and state governments that choose to expand the program.

The ACA expansion of Medicaid coverage will dramatically increase future Medicaid costs—primarily at the federal level, but also for those states that choose to expand the program as envisioned by the law. The extent of the cost increase, however, will depend on individual state's expansion decisions (many yet to be made).

In 2012, the Supreme Court effectively made the ACA's Medicaid expansion optional for the states by striking down the federal government's ability to compel states to expand coverage by withholding existing Medicaid funds for those who declined to comply. Blahous reviews the complex and competing incentives states face in the wake of the Supreme Court ruling. Specifically, each state must balance concerns about its own budgetary uncertainty and risk with the opportunity to significantly expand its citizens' health benefits while passing the vast majority of the bill to federal taxpayers, who mostly reside in other states.

Blahous further explains why—due to such factors as the "woodwork effect"—states that choose to expand should, on average, expect their total Medicaid expenditures to rise significantly despite the generous federal matching rate for newly eligible enrollees.

A Physician's Perspective
Darcy Nikol Bryan, MD

A physician explains her frustrations with Medicaid and discusses the need to refocus America's health care conversation on health rather than health insurance.

Dr. Darcy Nikol Bryan, an obstetrician-gynecologist surgeon in Riverside, California, details the challenges of working with the Medicaid system, such as the program's failure to cover treatments that would be most effective for patients.

Bryan discusses in detail the limitations of Medicaid—or any health insurance—in improving the health of low-income people. Health insurance will not provide patients with the life changes that could enhance their health, such as better nutrition or higher income, which Bryan sees as necessary components of improving the quality of life and health for her patients. She anticipates that the ACA's Medicaid expansion in California will decrease the state's already strained doctor-patient ratio, creating further challenges for the state's doctors who work with Medicaid patients.

Bryan suggests that to improve the quality of life for low-income Americans, policymakers should focus more broadly on people's overall well-being, rather than simply whether or not they have health insurance.

Reforming Medicaid
James C. Capretta, senior fellow at the Ethics and Public Policy Center

Successful Medicaid reform requires a fundamental transformation of the federal-state relationship.

The fundamental problems in Medicaid are rooted in its 1965 design, in which the federal government and state governments share in the program's financing and management—and in which neither is fully in charge. This design splits political accountability: federal officials blame states for using the program as a means to tap federal taxpayers to solve their budgetary problems, while states blame the federal government for imposing costly mandates and restricting their ability to best serve their population's specific needs. State government attempts to increase control via the flawed, subjective, and often politically driven "waiver" process results in additional tension and distrust.

Capretta finds the shared federal-state matching rate to be the primary driver of Medicaid's problems in that it creates conflicting incentives that discourage cost cutting and efficient patient care. Capretta considers the pros and cons of the most mainstream Medicaid reform proposals (block grants and per capita caps) as well as alternative solutions. He concludes that successful reform will fundamentally transform the nature of the federal-state relationship, and he prefers a system in which the federal government provides a fixed level of support through Medicaid, with the states deciding how to spend both federal funds and state resources to help their low-income populations secure health services.

How to Achieve Sustainable Medicaid Reform

Thomas P. Miller, resident fellow at the American Enterprise Institute

Medicaid provides second-rate care at first-rate costs. Improving this situation will require changing the incentives inherent in Medicaid financing.

Simplistic block grant reform proposals that aim only to slow the growth of federal spending will not solve longstanding structural flaws in Medicaid, such as lack of informed choices for beneficiaries, insufficient competition in benefits design, and poor incentives for improved health care delivery. The situation can be improved to some degree by setting separate per capita funding amounts for different categories of Medicaid beneficiaries and allowing state Medicaid programs more operational flexibility while holding them accountable for measured improvement in health care outcomes. But short of defined-contribution reforms that more directly subsidize and assist the most medically vulnerable Americans, simply handing off most important Medicaid decisions from federal to state officials does nothing to empower and engage individual beneficiaries.

Miller explains that Medicaid's fiscal pressures are driven by rapid enrollment growth rather than by excessive spending per beneficiary. Policymakers must re-target Medicaid assistance toward disabled, very low-income, and medically impoverished populations while they refocus overall economic policy to support stronger incentives to work, save, and invest. Better jobs and higher incomes, rather than larger taxpayer-subsidized transfer payments, remain the primary tickets out of unmet medical needs and less satisfactory health care for most low-income Americans.

Medicaid and Health
Robert F. Graboyes, senior research fellow at the Mercatus Center at George Mason University

The ACA's Medicaid expansion creates an additional strain on taxpayers but fails to achieve the objective of better health for low-income individuals.

While many of the book's authors emphasize the financial toll of Medicaid, Graboyes focuses on Medicaid's failure to deliver satisfactory health outcomes. He emphasizes the need for dramatic health care reform—both spending and regulatory—to foster "disruptive innovation," or technological and managerial advances that greatly reduce the cost of medicine and greatly increase the quality of care.

Drawing on the research of the book's other authors, Graboyes concludes that marginal reforms will not sufficiently improve Medicaid's quality of care or unsustainable fiscal path. Rather than expanding the fundamentally flawed program, Graboyes argues for replacing Medicaid with direct funding to low-income individuals who could then purchase their own private insurance. This would allow them to access the same health care available to others; it would also foster innovation and cost cutting, which would benefit all health care consumers.