

# The Next Priority for Health Care: Federalize Medicaid

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In 1982, President Ronald Reagan proposed a grand bargain: the federal government would become entirely responsible for financing Medicaid in exchange for giving states responsibility for more than 40 other federal programs, including Aid to Families with Dependent Children – the primary welfare program that President Clinton and Congress would radically reform 14 years later.

Previously, in 1969, 1977, and 1981, the U.S. Advisory Commission on Intergovernmental Relations, which comprised officials in all levels of government, had recommended that the federal government assume full financial responsibility for all public assistance programs, including Medicaid. The Commission argued that its ideas would greatly improve an intergovernmental system that had grown “more pervasive, more intrusive, more unmanageable, more ineffective, more costly and above all, more unaccountable.”

Reagan’s plan entailed basically the opposite of what the commission suggested, moving programs to the states, with the important exception of Medicaid. The motivation behind Reagan’s proposal was ideological — the promotion of what he called “a quiet federalist revolution” aimed at removing the federal government from a wide range of domestic activities while discouraging states and localities from replacing Washington’s efforts. Even so, there was widespread agreement that radical change was needed to fix the nation’s deeply dysfunctional system of federalism.

The “sorting out” idea never gained much traction, however, largely because of opposition from state officials. Reagan ended revenue sharing, reduced grants to state and local governments, and slowed spending on Medicaid and other safety net programs. In addition, the large deficits created by his 1981 tax cuts and generous defense spending became an ongoing rationale for austerity.

More than three decades later, federal-state relationships remain no less dysfunctional. The tumultuous legal and political battles over implementation of the Patient Protection and Affordable Care Act (known as Obamacare or the ACA), which is scheduled to take full effect in 2014, have laid bare why America’s highly decentralized system of federalism impedes effective responses to national challenges.

## Where We Stand: Obamacare and the Move Toward Medicaid Centralization

The health care legislation extends coverage to the uninsured through two main channels, both of which were intended by Congress to intimately involve the states. One of these is an expansion of Medicaid, the state-administered insurance program for low-income Americans and nursing home residents that is jointly financed by the federal and state governments. The other is through the creation of so-called insurance exchanges, which are governmentally organized and regulated marketplaces where uninsured Americans and small businesses can shop for health plans while paying premiums that will be partially covered by the federal government.

On both the Medicaid and insurance exchange fronts, unforeseen developments have greatly bogged down progress, and the decentralized system has exacerbated some

of the issues. The Supreme Court erected the surprise Medicaid hurdle in Chief Justice John Roberts' ruling upholding the constitutionality of the Affordable Care Act, allowing states to opt out of the legislation's requirement to extend Medicaid coverage to Americans with incomes up to 138 percent of the poverty level. That decision opened up an escape hatch that at least 10 states have already jumped through and another five are leaning toward – with an additional 12 remaining completely undecided.<sup>1</sup> Even though states would likely end up saving money from expanding Medicaid due to reductions in what they currently owe to medical providers for non-Medicaid uncompensated care,<sup>2</sup> it is possible that as many as half of all the states will fail to adopt that foundational element of Obamacare upon its launch in 2014.

Even worse from the standpoint of feeding public hostility to the law are the roadblocks that have emerged to rolling out the insurance exchanges. In many respects, uninsured citizens will form their judgments of health care reform based on their experiences with those exchanges, much as taxpayer views about government are shaped by their interactions with motor vehicle departments, the Internal Revenue Service, and post offices. While exchanges have often been analogized to commercial websites like Expedia.com, they are far more elaborate operations requiring a regulatory apparatus whose responsibilities include determining about which plans to include and exclude from the exchanges.

Another central problem facing the exchanges is how to minimize “adverse selection,” which arises when certain plans or exchanges enroll a relatively high-cost group of beneficiaries that leads to escalating premiums. Preventing and responding to adverse selection is an enormously difficult regulatory challenge that is essential to keeping the new system from unraveling.

In addition, health insurance plans are inherently complicated, so developing user-friendly interfaces to clearly present options to consumers will be critical to minimizing aggravation and enabling people to make sensible choices. Moreover, the exchanges are the mechanisms by which consumers are supposed to be able to learn the amount of their government subsidies for premiums and whether they are eligible for Medicaid.

All of those responsibilities were expected to be daunting

for the exchanges under the best of the circumstances. Optimists had predicted that governors would have a strong interest in creating and managing their state exchanges effectively to receive credit from their constituents and avoid blame. But instead only 18 states have taken up the challenge so far, with at least 25 defaulting the responsibility to the federal government.<sup>3</sup>

Political opposition has played an important role in many of the decisions to cede responsibility to the federal government, but in some cases administrative obstacles and difficulties in reaching a consensus about how to manage the exchanges have also bogged down the process. As a result of so many states demurring or dithering over whether to create exchanges, the Department of Health and Human Services has been left with an unexpectedly colossal job for which it is ill-prepared and inadequately financed.<sup>4</sup> Notwithstanding all of these unanticipated impediments to its federalist components, the Affordable Care Act remains

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a major step toward a more centralized health insurance system. States that have opted out of expansion, mainly due to ideological opposition, are likely to experience intense political and economic pressure to eventually go along with the broadened eligibility threshold in exchange for federal largesse that would flow to health care providers and beneficiaries. Because the federal government will bear nearly 93 percent of the costs of Medicaid expansion from 2014 to 2022 – a much higher share than it provides for current enrollees – states that continue to resist will be depriving their residents and medical institutions relative to participating states in ways that are likely to become highly visible and difficult to sustain.<sup>5</sup>

As the lion's share of states come to adopt the new broader eligibility threshold and the higher federal matching rate that comes with it, the federal government will gain greater leverage to exert control over additional reforms to the program. The next major medical care legislation should carry

the centralizing shift in control over Medicaid to its logical conclusion – full nationalization of Medicaid – which would greatly enhance both the health of the American population and of the nation’s system of federalism.

## Saving State Budgets

Converting Medicaid into a national program like the superior Medicare model, which covers virtually all of America’s elderly through rules and payment schemes that are consistent throughout the country, would relieve state governments -- even the recalcitrant ones now resisting health care reform -- of what has genuinely become an unmanageable financial burden. Soaring Medicaid costs, driven by rising enrollments and many of the same forces escalating inflation throughout the health care sector, have ensnared most populous states in a chronic budget squeeze that relentlessly forces cuts in education, social services, and other essential state-level functions. Even though state revenues have rebounded somewhat as the slow recovery continues, forecasts show that most states can expect to remain austere indefinitely as they comply with balanced budget requirements that don’t apply at the federal level.

Setting aside the reform bill’s changes to the program, which impose a minimal new burden on states notwithstanding Republican rhetoric, Medicaid as a whole really does threaten to crush state budgets throughout the country unless responsibility for it is further shifted entirely to federal control where it belongs.

Federalization would end the wide disparities among states in the share of the cost they owe per beneficiary relative to the federal contribution – a longstanding historical artifact without logical justification. Although the Affordable Care Act attempts to minimize disparate fiscal impacts among states as they implement the law, large variations will remain in the state share of the cost per Medicaid recipient. Complex administrative difficulties will arise as a consequence of the new federal matching payment schemes, which full nationalization could ultimately eliminate.

In addition, transferring Medicaid’s financial burden and administrative responsibilities from states to the federal level would create major new opportunities for controlling medical costs while enabling a greater share of lower-

income Americans to receive better care. And because the federal income tax is much more progressive than state revenue systems, federalization would move a higher portion of Medicaid’s costs onto Americans who can better afford to bear them while reducing administrative costs through economies of scale.

Politically, state-level unhappiness over both the mandated Medicaid changes in the health care legislation and the program’s central role in the chronic state fiscal quagmire has the potential to eventually unite red and blue state leaders in a push for federalization. With enrollment of non-elderly Americans in Medicaid and the CHIP plan for children projected to increase by about 25 percent, to 43 million, by 2022 even after taking into account the negative impact of the Supreme Court decision,<sup>6</sup> the program’s myriad shortcomings can be expected to attract greater public attention and scrutiny than in the past. While it has long been apparent to most policy analysts that those flaws largely derive from Medicaid’s bifurcated federal-state status, Medicaid’s centrality to the health reform bill may well lead a critical mass of political constituencies to recognize that the unavoidable next step for reform is federalization. States’ rights advocates may come to see that shedding Medicaid obligations through federalization would liberate state governments to pursue their own goals more freely while cutting state taxes. Even some deficit hawks worried about the federal debt, who can be expected to be the strongest opponents of federalization, may be persuaded that Congress can better constrain Medicaid’s costs when it fully controls the program. However the politics of the issue plays out, the changes set in motion by the Affordable Care Act are likely to build an even stronger substantive and political case than previously existed for federalizing Medicaid.<sup>7</sup>

## Following the Money

Obamacare’s heavy reliance on states to carry out reforms to cover the uninsured, including the creation of state-based insurance exchanges along with the Medicaid expansion, perpetuates the nation’s long history of decentralized support for the disadvantaged. Before the New Deal, domestic federal spending was only about 20 percent of state and local outlays.<sup>8</sup> Only the old age pension provisions of the 1935 Social Security Act devised an entirely federal system, while funding and implementation responsibilities

were shared between the national and state governments with respect to unemployment insurance and supports for needy women, children, and the elderly. Race loomed large in the Congressional debates leading up to the creation of America's social insurance system, with representatives of southern states largely winning their demands to retain control over determining eligibility and benefit levels to prevent interference in how they addressed "the Negro question."

That pattern continued as federal support for medical care evolved, beginning with 1950 amendments to the Social Security Act authorizing federal payments for health care expenses of individuals deemed needy by states. The 1960 Kerr-Mills Act, which extended coverage to "medically indigent" individuals over 65 not receiving Social Security's old age assistance, established a "federal matching percentage" ranging from 50 to 80 percent of state outlays, varying inversely with a state's per capita income. That basic formula became enshrined in Medicaid upon its enactment five years later, with a top matching rate of 76 percent for the poorest states, and essentially continues to this day. Arkansas Democrat Wilbur Mills, the fiscally conservative chairman of the House Ways and Means Committee, designed Medicaid to be both independent of Medicare and administered through a joint federal-system in part to prevent Medicare from becoming the "entering wedge" for a nationwide "compulsory" system of health insurance for everyone.<sup>9</sup> The upshot is that the least populous and economically poorest states, which are apt to be most disdainful toward the federal government, also receive a disproportionate share of national support for Medicaid. Indeed, most of the states opting out of Medicaid expansion would receive substantially more per capita from the federal government than those that are adopting the broader eligibility provisions.

The Children's Health Insurance Program (CHIP), created in 1997 to extend coverage to kids from low-income households not eligible for Medicaid, has higher federal matching rates ranging from 65 percent to 83 percent. Those levels have the effect of reducing the cost to a state of covering a child by 30 percent when compared to the regular Medicaid matching rate. Although CHIP is a companion program to Medicaid, it differs in that it makes a capped amount of money available to states as a block grant each fiscal year.

Under the Affordable Care Act, the federal government will pay the entire freight from 2014 to 2016 for individuals who become newly eligible for Medicaid under the mandated standard of 138 percent of the federal poverty level, almost all of whom will be childless adults. That matching rate gradually ratchets down to 90 percent by 2020, where it will remain thereafter. The law also includes provisions providing some financial relief to relatively generous states that already allowed low-income adults without children to enroll in Medicaid. Otherwise, they would essentially be punished for their past generosity with much lower federal matching rates for existing beneficiaries than states that never covered childless adults will receive. At least seven states – Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont – will receive enhanced matching rates for childless adults who had been enrolled in Medicaid as of December 1, 2009. (In addition, beginning in October of 2015, states will receive an increase of 23 percentage points -- up to a maximum of 100 percent -- in their CHIP match rate.)<sup>10</sup>

While it's laudable that the health care legislation's much higher matching federal rates for new enrollees includes some supplemental assistance for states that paved the way to reform, the wide assortment of payment levels both among and within states, and from one year to the next, defies any sane non-political justification and poses all kinds of costly administrative headaches. Why, say, should the federal government pay the full cost of a newly eligible 35-year-old man in Arkansas earning 125% of the poverty level while requiring California to foot half the bill for a pregnant woman with the same income?

Greatly compounding the confusion is the fact that many individuals who were already eligible for Medicaid under a state's existing rules but who only sign up later as a result of the legislation's individual mandate, new outreach measures, or some other factor, may not receive the higher federal matching rate. Particularly for enrollees with incomes near a state's previous eligibility threshold as of the December 2009 cutoff date, sorting out the appropriate payment level after the new system takes effect in 2014 will be difficult. The federal Center for Medicaid and CHIP Services has been working with states to develop alternative methodologies to make such eligibility determinations, but there will be no simple solution.<sup>11</sup>

In manipulating the federal matching formulas to induce

much higher Medicaid enrollments and cooperation from states, Congress has twisted the system's always problematic payment scheme into contortions that may no longer be workable. One undeniable argument for complete federalization is that it would in one fell swoop eradicate the impossible-to-defend, difficult-to-implement variations in state financial responsibility for Medicaid enrollees across the country. That the health care act initially provides full federal funding for new enrollees in order to maximize state cooperation and recruit as many beneficiaries as possible in its own right suggests that eliminating the state financing obligation altogether is the path toward making the entire system work better.

## Medicaid's Flaws

In addition to Medicaid's wide variations in matching rates and eligibility criteria, the program has long been plagued by other shortcomings that the Affordable Care Act attempts to redress to some extent, but which would much more effectively be resolved under full federalization. Those problems include states failing to enroll residents who are eligible for coverage, constraints that limit the access of Medicaid beneficiaries to decent care, rapidly rising costs that are the single biggest cause of chronic state budget shortfalls, and poor coordination of services for high-cost individuals covered by both Medicare and Medicaid. Briefly, here's why building on the health care reform act to move further toward full federalization would be even more effective at overcoming those problems:

### Enrollment Gaps

Before welfare reform in 1996, eligibility for Medicaid was linked to qualifying for Aid to Families with Dependent Children, which stigmatized Medicaid and connected it to an enormously cumbersome application process and hostile bureaucratic culture. Although some states have made great strides since then in streamlining Medicaid's sign-up procedures and reaching out to enroll eligible low-income pregnant women and children, a large proportion of those who qualify for coverage remain uninsured.

A 2008 study by the National Institute for Health Care

Management Foundation concluded that about one in four non-elderly Americans without health coverage, or about 12 million people, were eligible for Medicaid or CHIP but not enrolled in them.<sup>12</sup> Another report by the Kaiser Commission on Medicaid and the Uninsured, which focused on 13 states, found wide variation in enrollment rates among them, with Mississippi at the low end covering only 36 percent of residents eligible even under its very limited criteria.<sup>13</sup>

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The health care bill includes reforms intended to substantially increase Medicaid take-up rates, including the individual mandate requiring everyone to sign up for some kind of coverage to avoid a fine. Other constructive provisions in the legislation include elimination of asset tests that many states still apply in determining eligibility of adults, adoption of a uniform method for determining income eligibility (called modified adjusted gross income) in contrast to widely varying systems among states, and greater state discretion to presume individuals are eligible with minimal paperwork. In addition, the law requires states to establish a website through which residents can apply for Medicaid or CHIP as well as the coverage offered in state-based exchanges.

In the aftermath of health care reform's enactment, Kaiser and Lake Research Partners interviewed Medicaid program directors and other experts on questions related to improving outreach and enrollment in the program. The consensus view was that the legislation presented an opportunity to foster a new "culture of coverage" and recast the program as the source of affordable coverage for working people and families -- in contrast to its stigmatized past. Some states, thanks largely to CHIP and its extension of coverage to children from families with incomes significantly above the poverty level, made important progress in simplifying Medicaid enrollment and renewal processes

for children. Doing the same for adults, the Kaiser report argues, will require a “culture shift...to reorient Medicaid management, systems, and caseworker training away from welfare-style ‘gatekeeping’ and toward encouraging participation.”<sup>14</sup>

Transforming any culture, particularly in a state governmental bureaucracy, is inherently slow and uncertain work that at a minimum requires leadership committed to changing the ways that employees view their jobs. Notwithstanding all of the sound reforms in the health care bill intended to streamline the Medicaid enrollment process, many states, especially those balking at Medicaid expansion, may not be dedicated to undertaking changes in their bureaucratic culture because their top officials resent everything about the law. The federal government can try to encourage those states to reach out to newly eligible low-income adults, and even finance almost the entire cost, but there’s every reason to expect recalcitrance that will leave large gaps between Medicaid eligibility and actual enrollment. Only full federalization could overcome that basic problem by transferring ultimate responsibility for administering the program to federal authorities.

### Limited Access to Quality Care

Because federal rules define categories of services that Medicaid must cover, and because the stimulus and health care bills have temporarily prohibited states from weakening their eligibility criteria, states facing budget shortfalls are left to reduce Medicaid spending mainly by squeezing the rates they pay to medical care providers and cutting back coverage of non-mandatory services. In the years following the Great Recession, most states significantly cut Medicaid provider rates and benefit packages. Only in fiscal 2013 has that pressure on reimbursement levels and benefits finally begun to abate.<sup>15</sup> Those reductions and constraints have had the effect of limiting the treatment options available to many Medicaid beneficiaries.

A study by Sandra L. Decker of the National Center for Health Statistics found that in 2011, 31 percent of physicians were unwilling to accept any new Medicaid patients, compared to 17 percent unwilling to accept new Medicare patients and 18 percent privately insured patients. Controlling for other factors, acceptance rates of new Medicaid patients were lower in states with lower Medicaid

to Medicare fee-for-service fee ratios. The state with the lowest percentage of physicians accepting new Medicaid patients was New Jersey (about 40 percent), which also has the nation’s lowest Medicaid-to-Medicare fee ratio.<sup>16</sup>

Other studies have determined that the care of Medicaid patients has become increasingly concentrated among a relatively small proportion of doctors who tend to practice in large groups, hospitals, academic medical centers, and community health centers. Some of those hospitals receive higher reimbursements provided by the federal government for treating a “disproportionate share” of Medicaid and uninsured patients. Researchers Peter Cunningham and Jessica May didn’t assess the quality of care in those centers, but concluded, “If these Medicaid providers experience increased financial pressures and rising patient demand, quality of care and access to some services could be negatively affected.”<sup>17</sup>

In 2008, Medicaid’s reimbursement levels to health care providers nationwide were only 72 percent of those for Medicare. In New York, New Jersey, and Rhode Island, they were less than half of Medicare’s rates. Not coincidentally, New York also ranked dead last among the states in preventable hospitalizations and poorly on other measures of health care quality by the Commonwealth Fund, even though its Medicaid program covers a broader array of services than most states offer. A variety of forces contribute to New York’s bad record, but low reimbursement rates are an important factor partly because they lead many Medicaid patients to be treated in overcrowded institutional settings that often fail to offer adequate individual attention.<sup>18</sup>

Many states also have been cutting back Medicaid support for particular services, leaving low-income individuals with special needs in the lurch. Among the most vulnerable are the disabled and those with mental health issues. Even though the average cost for disabled Medicaid patients has declined relative to inflation over the past 15 years as institutional care for them became supplanted by less costly in-home services, many states desperate for savings have reduced coverage of home-based care. In addition to creating hardship for the patients, those reductions ultimately could boost Medicaid costs by forcing some of those individuals to return to institutions.<sup>19</sup>

The health care bill includes a number of constructive changes aimed at helping to address these access problems

for Medicaid patients. For example, it requires states to pay full Medicare rates for primary care services in 2013 and 2014, with the payment increase entirely financed with federal money. It also provides additional funds for community health centers, which provide care for many Medicaid patients. Typically, they are found in low-income areas, are open “after hours,” and can serve as an alternative to the emergency room. When a Medicaid patient receives basic care in an emergency room, the bill is needlessly inflated by the costs of ER’s technological equipment -- which may not be needed for patients suffering from relatively minor problems. Community clinics can save money while giving Medicaid patients continuity of care in a setting better suited to their needs. Unfortunately, these clinics are also highly vulnerable to federal and state budget cuts, as Congress demonstrated in 2011 by reducing the money initially made available in the Affordable Care Act for new centers.

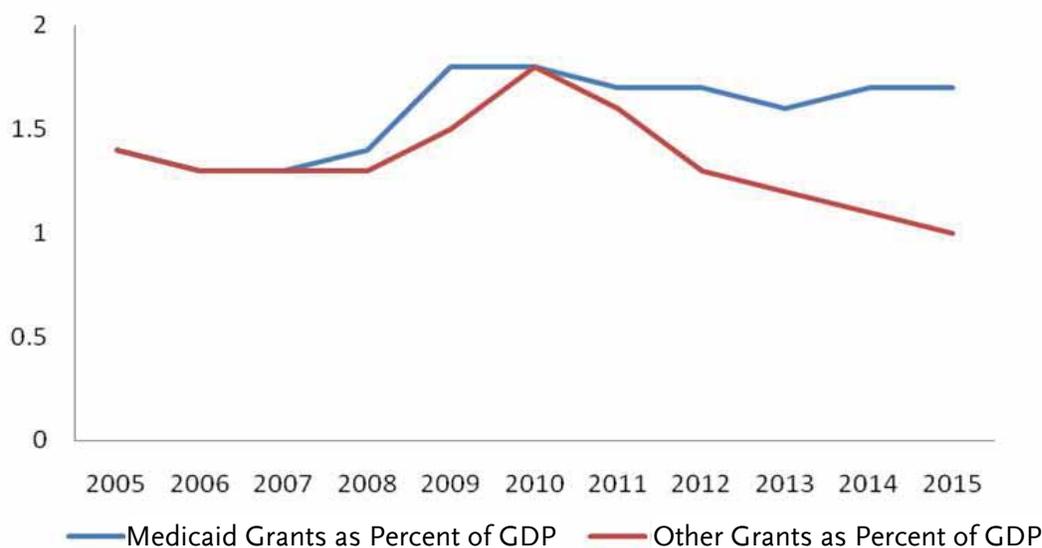
In and of itself, the sizeable and sometimes yawning gaps between Medicare and Medicaid reimbursement rates to health care providers sustains Medicaid’s status as a second-tier welfare program. With states likely to remain under relentless budgetary pressures, they can be expected to continue to look for savings through relatively blunt and painful Medicaid cuts that primarily affect low-income residents who lack political clout.

Federalization wouldn’t eradicate those political forces by any means. But it would help to greatly reduce the fragmentation in the health care system that creates so many inefficiencies and inequities, including the poor access to high-quality care available to Medicaid beneficiaries in many states. Setting reimbursement levels at the federal level has helped Medicare to sustain a much higher degree of provider participation and enthusiasm than Medicaid has experienced. Federalization would greatly increase the probability that Medicaid reimbursement levels would be linked nationally to Medicare’s, reducing state-to-state variability in access to quality care while broadly improving it across the country.

### Soaring Costs

Like private health insurance and Medicare, Medicaid has experienced cost increases well in excess of overall inflation during most years of the past few decades. In part, the same forces that have driven soaring medical inflation throughout the U.S system are responsible, including rapid adoption of expensive new technologies and the prevalence of fee-for-service compensation that rewards the performance of procedures that are often not medically necessary or appropriate. But Medicaid’s costs also climbed rapidly before leveling off because of large enrollment increases arising from the recession, which knocked

Figure 1: State and Local Government Grants, as a Percentage of GDP



Source: Historical data are from the Bureau of Economic Analysis, NIPA. GAO simulations are from 2010 - 2015 based on current policy.

incomes beneath eligibility thresholds for a larger share of the population.

The improving economy in fiscal 2012 helped to reduce the overall increase in total Medicaid spending to 2.0 percent as enrollment growth plummeted and health care costs generally flattened out.<sup>20</sup> While some analysts have expressed optimism that industry-wide adjustments in anticipation of the Affordable Care Act's full implementation are already helping to contain costs, broader economic forces seem most likely to be responsible for the recent lull in medical inflation.

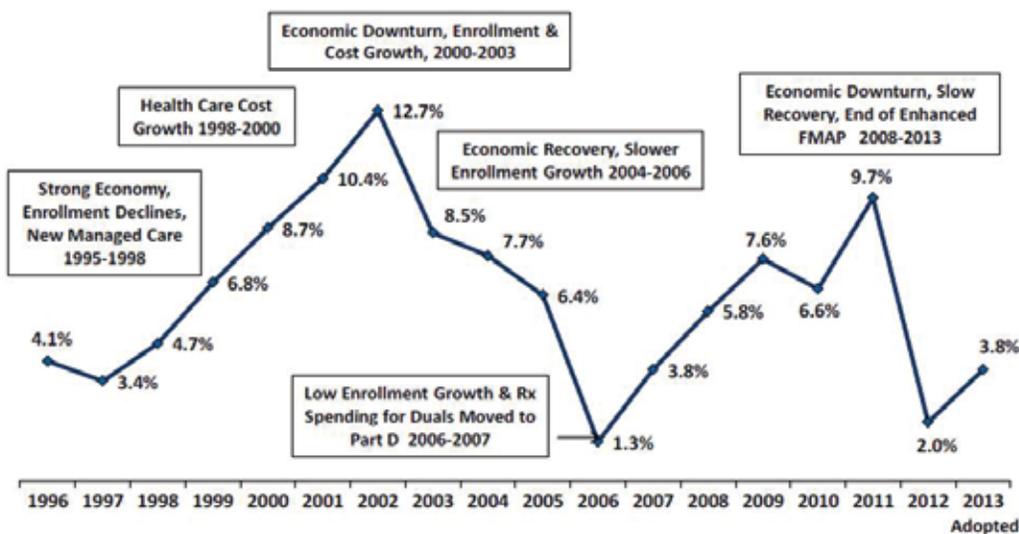
One of the most universally praised elements of Obamacare, even from some Republicans who opposed it, is its inclusion of provisions intended to simultaneously control costs while enhancing the quality of care. Those changes largely focus on Medicare, since it's the program over which the federal government can exert the most control. Innovations like the creation of an Independent Payment Advisory Board to make cost-effectiveness recommendations for Medicare, adjustments to Medicare payment changes tied to the productivity of providers, and numerous other large and small experiments have the potential to help achieve the Obama administration's goal of "bending the health care cost curve."

Whichever of those cost-control strategies turn out to

work best would be much more powerfully transmitted throughout the health care sector if they could be applied nationwide to Medicaid as well (some states are emulating various cost-savings ideas). One long-standing difficulty with the nation's past unsuccessful efforts to rein in costs has been the system's propensity to react like a squeezed balloon: controlling spending in one realm can lead to expanding outlays somewhere else in the system. For a time in the 1990s, the increased adoption of managed care plans by private insurers helped to hold down their costs, but Medicare simultaneously experienced more rapid inflation. Before that, changes in Medicare that succeeded in constraining its costs coincided with soaring spending in the private insurance market. If successful cost-control tactics could be carried out together by Medicare and Medicaid, the federal government would have greater leverage over the entire balloon. But that would only be possible to implement in earnest if Medicaid were to be fully federalized.

In the absence of federalization, projections by the Government Accountability Office show that state governments will be squeezed in an ever-tightening budgetary vise even after the economy fully recovers. Even though the new health care bill in its own right won't add much pressure, the ongoing Medicaid responsibilities for states (as well as their pension and medical insurance commitments to current and former state workers) will be so bur-

Figure 2: Total Medicaid Spending Growth, FY 1996 - FY 2013



Source: Kaiser Family Foundation, "Medicaid Today." Data for FY 2000-2011 - Historic Medicaid Growth Rates, KCMU Analysis; FY 2012-13, KCMU survey conducted by Health Management Associates, 2012, <http://www.kff.org/medicaid/upload/8380.pdf>.

densome as to leave them in a perpetual austerity mode. With all states but Vermont legally obligated to maintain balanced operating budgets each year, the GAO calculated that closing the projected fiscal gaps would require action to be taken today and maintained each and every year going forward equivalent to a 12.7 reduction in state and local government expenditures – or comparable tax increases.<sup>21</sup> For state budgets, health care commitments are like Otto, the relentlessly expanding pet goldfish in the children’s book.

The Congressional Budget Office projects that state spending for Medicaid and CHIP would amount to about \$2.6 trillion from 2014 through 2022 without health care reform plus another 2-3 percent more to be added because of the legislation.<sup>22</sup> But while deficit hawks will recoil at the thought of shifting that burden from the states to the federal government, keep in mind five realities: 1) Americans have to pay the Medicaid bill one way or the other, whether out of their federal or state taxes; 2) because state sales, “sin,” and flat income taxes are regressive, low- and middle-income Americans bear a greater share of that cost than they would if it were paid through the much more progressive federal income tax; 3) constraining costs would be much more manageable under a system in which

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one level of government bears full responsibility for the program’s success, in contrast to the divided federal-state accountability responsible for Medicaid’s myriad shortcomings; 4) because the federal government is not bound by balanced budget requirements that govern states, the widespread public health problems that worsen during economic downturns can be much more effectively mitigated; and 5) by relieving state budgets of Medicaid, governors would regain the flexibility to much more effectively manage their states.

If federalizing Medicaid seemed like a good idea to Ronald Reagan, who proposed it in 1982, Republicans and other

deficit hawks ought to think harder about the possibility rather than dismissing it out of hand.

## The “Dual-Eligible” Challenge

About 8.9 million Medicaid beneficiaries are enrolled in Medicare as well, according to the most recently available figures from 2007. About 60 percent of those “dual-eligibles” are frail elderly Americans with very low incomes, many of whom live in nursing homes. Most of the remainder are low-income individuals with disabilities. Although dual-eligibles constitute only about 15 percent of Medicaid enrollees, around 40 percent of the program’s spending is devoted to these especially unhealthy and impoverished individuals.<sup>23</sup> Medicaid pays for their Medicare premiums and cost sharing, as well as important benefits that Medicare does not cover like long-term care services.

Because dual-eligibles are among the costliest of Americans for the federal and state governments to insure, and because both payment structures and medical care for them tend to be highly fragmented, they are an important focal point for reform. The health care bill included numerous provisions intended to streamline care and coverage for dual-eligibles, including higher federal matching payments to states for creating a “single entry point system” for access to long-term care systems and supports, and applying standardized methods for determining eligibility for non-institutional services. Additional federal money is also available to states for facilitating the transition of nursing home residents to home- and community-based systems of care, among other incentives. Moreover, the legislation established a new office in the Centers for Medicare and Medicaid Services charged with improving coordination between the Medicare and Medicaid programs on behalf of dual-eligibles.<sup>24</sup>

While all of those reforms are constructive, their reliance on incremental increases in federal matching rates to induce changes in state policies toward dual-eligibles is a cumbersome, highly uncertain, and administratively costly lever to rely on. Some states will no doubt ignore the incentives entirely, while others will pick and choose among them, once again yielding highly scattershot outcomes across the country. Here, too, the legislation moves in the right direction while underscoring that Medicaid

federalization would be a much more reliable, effective, and cheaper way to achieve the desired results.

## The Road to Federalizing Medicaid

Unfortunately, debates over America's fiscal condition invariably focus on the outlook for the federal budget while neglecting how any sensible accounting of governmental revenues, outlays, and debt ought to integrate states and localities as well. In America's highly decentralized system of government, federal and state budgets are inextricably intertwined in myriad complex ways. But one basic reality is quite simple: the central fiscal problem confronting both the federal government and the states is the prospect of a continuation of rapidly rising health care costs. Viewing that challenge through the rarely used lens of federalism rather quickly clarifies that one of the most promising strategies for controlling those costs in ways that would ultimately strengthen the fiscal condition of both levels of government would be to federalize Medicaid. For the states, relieving them of the number one obligation causing their financial distress would enable them to regain the capacity to function much more effectively. For the federal government, taking over Medicaid would entail large new outlays, but it would also create much greater leverage in directly confronting the underlying problem of soaring medical inflation. In the process, the cost of providing health care to lower-income Americans would shift toward those who can most afford it under the federal government's more progressive tax structure. Not incidentally, more citizens would be likely to receive better care in good times and bad regardless of what state they live in.

The Affordable Care Act, which pushed Medicaid in the direction of federalization across the broad array of fronts summarized in this brief, demonstrates that there is political support to at least move in that direction. And the opposition of many conservative states to the legislation's Medicaid mandates suggests that at least some conservatives might be persuaded that, from a state's rights perspective, complete federalization would be preferable to more mandates. The primary political challenge will be to convince deficit hawks that federalization is one of the most promising strategies for controlling health care costs, which in turn is far and away the best way to improve the long-term fiscal outlook at all governmental levels. In that

context, a politically acceptable approach for financing the added federal costs would need to be agreed upon, as it was for the health care bill with its higher taxes on investment income and costly employee health insurance plans. Part of that sales job will include emphasizing the corresponding reductions in state taxes relative to what they would otherwise need to be.

Logistically, there are two primary approaches that should be pursued to phase in federalization of Medicaid. One entails federal assumption of the full cost of dual-eligible Medicaid and Medicare beneficiaries, and the other involves ratcheting up federal matching payments for Medicaid and CHIP until the 100 percent threshold is reached. In both cases, a variety of alternative steps could be pursued to make the transition as the federal government takes over increasing responsibility for the program's implementation:

### Assuming the Cost of Dual-Eligibles

Researchers from the Urban Institute and the Robert Wood Johnson Foundation calculated that fully 80 percent of the cost of dual-eligibles is already covered by the federal government, with the states paying \$62.7 billion of the \$319.5 billion spent on those individuals in 2011. More than 70 percent of the state outlays are directed toward long-term care services.<sup>25</sup>

In and of itself, federalizing only the dual-eligible population would provide substantial financial relief to the states while greatly enhancing opportunities to improve coordination of the care of these especially unhealthy and poor individuals. And because they are unusually expensive as well, implementing cost-effectiveness strategies nationwide – especially with respect to long-term services – could help to make a significant dent in overall health care inflation. The Medicare Payment Advisory Commission estimated that shifting dual-eligible patients from Medicaid-financed nursing benefits to Medicare-financed hospital and skilled nursing facility benefits could potentially reduce costly rehospitalizations between 18 percent to 40 percent.<sup>26</sup> Concentrating accountability at the federal level would create a much more transparent and robust regulatory environment for improving the system over time.

## Ratcheting up Matching Rates

The health care reform bill's full federal funding for newly eligible Medicaid beneficiaries from 2014 through 2016 puts a foot in the federalization door that the Obama administration and Congress should try to walk through with the next round of reforms. Instead of implementing the slight reduction in federal support for those individuals beginning in 2017, the 100 percent rate for newly eligible enrollees should be made permanent. And to rationalize Medicaid's jerry-rigged payment system at long last, matching rates for everyone else should also be increased over time so that ultimately the federal government pays full freight for everyone.

One way to do that would be to restore the higher matching rates that were temporarily put into effect in the stimulus legislation that Congress enacted during the financial crisis. Then, after a period of time, those rates could be further increased until every state's beneficiaries were fully covered by the federal government. Raising the existing baseline rates across the board by the same number of points would help to minimize infighting among the states. Alternatively, Medicaid matching rates could be raised to the higher post-health care reform CHIP levels as a next step, and then increased from there until full federal funding is reached.

Although states are projected to spend about \$2.7 trillion on Medicaid from 2014 through 2022, the price tag of federalization could be reduced significantly below that figure by gradually phasing in the changes beginning in that period and extending into the next decade. Still, the cost to the federal government will be significant, just as the savings will be to the states.

Financing the transition to Medicaid's federalization and then sustaining a sufficient level of support going forward should probably entail some combination of an additional source of revenue deriving from upper income taxpayers coupled with a modest payroll tax increase on all workers that would be earmarked for services provided to current dual-eligibles. Because taxing income from investments at the same rate as income from work would enhance both the fairness and simplicity of the tax code, and would emulate changes made under President Reagan in 1986, that reform would be sensible policy in its own right and would go a long way toward financing the transition to Medicaid

federalization. The recent tax code changes reducing the favorable treatment of capital gains and dividend income are an important step in that direction, though the additional revenue is not earmarked for any purpose.

Although raising the existing Medicare payroll tax to help finance the transition to Medicaid federalization would be an arduous sell politically, targeting an increase to pay for long-term care services would be more plausible than a hike to cover the broader Medicaid population. Since literally anyone can end up near destitution due to a disease like Alzheimer's or other severe disabilities, the rationale for requiring all workers to pay into the long-term care protections in the social insurance system is similar to that underlying the universal coverage of Social Security and Medicare. A payroll tax rate increase of about 0.5 percent would be roughly sufficient to cover the costs of merging dual-eligibles into Medicare, which in turn is a little less than half the cost of full federalization of Medicaid.

All Americans would ultimately benefit from a much more effective system for providing health care to its most vulnerable citizens, including low-income children, because today's jerry-rigged, scattershot approach is a drain on the economy and is killing state budgets. Increasing federal revenues to pay for the transition would ultimately produce widely shared benefits extending far beyond Medicaid's current and future beneficiaries. By helping to bring overall medical inflation under control, federalizing Medicaid would ultimately pay for itself by squeezing out much of the rampant waste in the existing system.

## Conclusion

Federalizing Medicaid would by no means be sufficient to repair all that ails America's health care system, which will remain deeply flawed even after the Affordable Care Act is fully implemented. But it's an essential next step to further move toward reducing the fragmentation that lies at the heart of the dysfunction. If Medicaid were to be federalized, that would create new possibilities for later merging it with Medicare, or a new public insurance plan that would be made available to everyone on the state insurance exchanges. Reducing the isolation of Medicaid's stigmatized population by integrating them into a system that serves the non-poor as well has the potential to improve their health and overall cost-efficiency even more.

Sooner or later, America's historical enthusiasm for decentralized governance will give way to the recognition that our system of federalism has become broken and unsustainable. Health care is the one realm of public policy

where fairly straightforward, if politically challenging, reforms could make all levels of government work better while restoring their fiscal health.

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