

POLICY PAPER

# THE NEXT PRIORITY FOR HEALTH CARE: FEDERALIZE MEDICAID

GREG ANRIG

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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.



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## Introduction

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, 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.

Nearly three decades later, federal-state relationships remain no less dysfunctional. One of the fundamental reforms in this year’s Patient Protection and Affordable Care Act is its commitment to enroll in Medicaid all non-elderly Americans with incomes up to 133 percent of the poverty line. That new national obligation for a program that has embraced an enormous degree of state discretion since its inception in 1965 has already aroused the ire of much of the South, parts of the West, and a handful of Republican attorneys general from northern states. Twenty states have joined in a lawsuit led by Florida Attorney

General Bill McCollum protesting the legislation as “an unprecedented encroachment on the liberty of the individuals living in the Plaintiffs’ respective states.”<sup>1</sup>

Many of the suit’s legal and substantive claims actually encroach on absurdity, but the instant rebellion underscores the inherent difficulty of pursuing national goals through a program built on strong state autonomy. Medicaid has always been plagued by inequities, inefficiencies, and scattershot effectiveness, largely because its dual federal-state character diffuses accountability and some state governments simply don’t care much about the poor. Those problems will no doubt impede the legislation’s goal of expanding the program’s enrollment from today’s 60 million to 84 million by 2019.<sup>2</sup> But the good news is that the new law takes important steps toward moving Medicaid down a path toward full nationalization, with the federal government bearing 96 percent of the cost of the program’s expansion over the next 10 years.<sup>3</sup> The next major medical care reforms should carry that centralizing shift in control over Medicaid to its logical conclusion, which would greatly enhance both the health of the American population and of the nation’s system of federalism.

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 parsimonious ones suing the feds -- 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 after the effects of the severe recession abate, 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.

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The howls of protest over the largely imaginary new state financial obligations in the legislation are unfounded. Most states suing the national government will receive a disproportionate share of new federal money to cover a higher portion of their populations, with their minimal new Medicaid obligations outweighed by money they no longer will have to spend to subsidize uncompensated care for the poor. But

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setting aside the reform bill's changes to the program, Medicaid 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 reform legislation 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 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 unite red and blue state leaders in a push for federalization. With enrollment in Medicaid

expected to climb to more than one-fourth of the non-elderly population over the next 10 years – and over 133 percent as many beneficiaries as Medicare will have -- 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 rising 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 new legislation makes an even stronger substantive and political case than previously existed for federalizing Medicaid.<sup>4</sup>

## Following the Money

The health care legislation'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>5</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

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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>6</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. (Under last year’s American Recovery and Reinvestment Act, federal matching rates were temporarily increased by about 11 percentage points – a hike that will expire at the end of 2010 in the absence of Congressional action).

The Children’s Health Insurance Program, 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.

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Under the health care bill, 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 133 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>7</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 Georgia 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, won't 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. States also will have a strong incentive to err on the side of assuming such an individual was not eligible under the state's previously existing system in order to attain more federal support.

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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 bill 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 health care legislation 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>8</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>9</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>10</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, particularly those suing over the legislation, 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.

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## 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 fiscal 2010, 39 states either cut Medicaid provider rates or froze payments to hospitals and/or nursing homes." Those reductions and constraints have the effect of limiting the treatment options available to many Medicaid beneficiaries.

Researchers Peter Cunningham and Jessica May found that about one fifth of physicians in 2004-2005 said they were not accepting new Medicaid patients, primarily because of low reimbursement rates and high administrative costs. Only 40 percent of doctors accepted all Medicaid patients. More significantly, the researchers determined that care of Medicaid patients was becoming increasingly concentrated among a relatively small proportion of doctors who tend to

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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. Cunningham and 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>12</sup>

*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.*

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>13</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>14</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 enough additional funds to double the capacity nationwide of community clinics, 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.

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

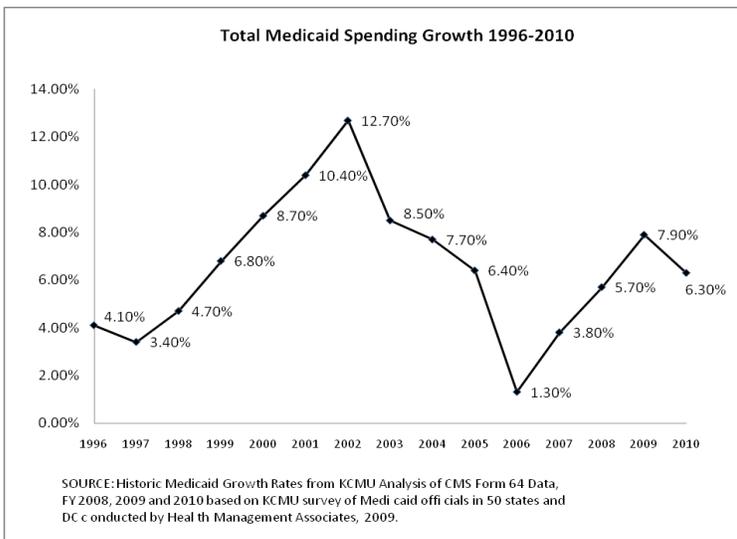
Medicaid beneficiaries in many states. Setting reimbursement levels at the federal level has helped Medicare to sustain a much higher degree of provider participation and enthusiasm than Medicaid has experienced. Federalization would greatly increase the probability that Medicaid reimbursement levels 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 driving 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 have also climbed rapidly because of large enrollment increases, which lately have been an outgrowth of the recession's knocking incomes beneath eligibility thresholds for a large share of the population.

In state fiscal year 2009, total Medicaid spending increased by 7.9 percent -- the largest hike since the end of the last economic downturn in 2003. As recently as 2006 and 2007, Medicaid's growth dropped to record lows due to the economic recovery and the implementation of the Medicare Part D prescription drug benefit, which transferred drug costs for individuals covered by both Medicare and Medicaid to just Medicare. But as with other categories of health insurance that also have experienced brief interludes of relatively low inflation, Medicaid's outlays have once again spiked and seem sure to be headed ever upward as the program expands under the new legislation.

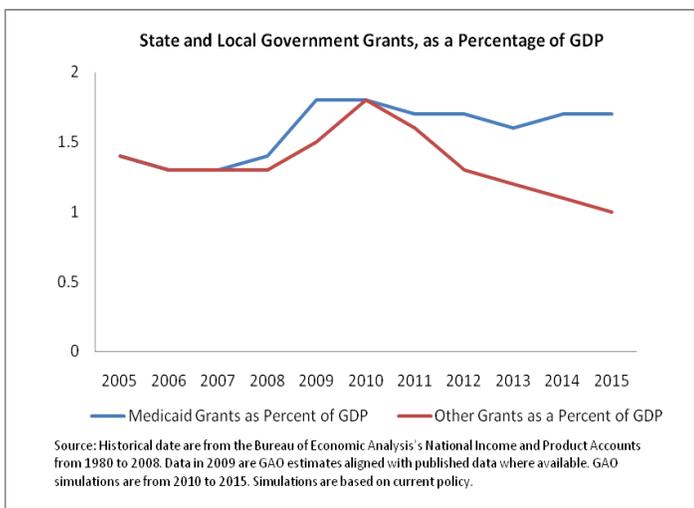
One of the most universally praised elements of the health care legislation, even from some Republicans who opposed it, is its inclusion of provisions intended to simultaneously control costs while enhancing the quality of care. Those changes largely focus on Medicare, since it's the program over which 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 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 burdensome 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 12.3 reduction in state and local government expenditures – or comparable tax increases.<sup>15</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 states will spend \$1.6 trillion on Medicaid from 2014 through 2019,

which is about twice the added federal health care spending under the new legislation. But while deficit hawks will recoil at the thought of shifting more of 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 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 8.8 million Medicaid beneficiaries are enrolled in Medicare as well, according to the most recently available figures from 2005. About two-thirds of those "dual-eligibles" are frail elderly Americans with very low incomes, many of whom live in nursing homes. The other third are low-income individuals with disabilities. Although dual-eligibles constitute only about 18 percent of Medicaid enrollees, around 46 percent of the program's spending is devoted to these especially unhealthy and impoverished individuals.<sup>16</sup> Medicaid pays for their Medicare premiums and cost sharing, as well as important benefits that Medicare does not cover like long-term care.

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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>17</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 primary political challenge will be to convince deficit hawks that federalization is one of the most promising strategies for controlling health care costs.*

The content of this year’s health care legislation, 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 southern states to the bill’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.

*Federalizing only the dual-eligible population would provide substantial financial relief to the states.*

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 Kaiser Commission on Medicaid and the Uninsured recently calculated that fully transferring the cost of dual-eligibles to the federal government would shift \$46.8 billion in annual spending away from the states, based on 2005 figures. The lion's share of that figure, \$33.5 billion, is attributable to long-term care services. In addition, federal assumption of

the full cost of Medicare-covered services (the deductibles and co-insurance that Medicaid now pays) would amount to \$7.6 billion; the state's share of Medicare premiums paid by Medicaid would be \$3.7 billion; and acute care services like vision and dental care not covered by Medicare would be \$2.1 billion

As a share of all state Medicaid spending, dual-eligible outlays amount to about 41 percent. States that spent half or more of their Medicaid dollars on dual-eligibles include North Dakota (59 percent), Connecticut (58 percent), New Hampshire (55 percent), Wisconsin (54 percent), Pennsylvania (50 percent), and Nebraska (50 percent).<sup>18</sup> All other considerations being equal, states with lower matching federal rates would enjoy a relatively larger decline in their Medicaid obligations.

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. Exactly what those policies and standards might entail would be subject to debate, but 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

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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 first retain the higher matching rates under the stimulus bill for a period of time, and then gradually add 5 or 10 percentage points a year until every state's beneficiaries were fully covered by the federal government. Increasing 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 \$1.6 trillion on Medicaid from 2014 through 2019, 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.

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. The health care bill includes a meaningful step in this direction with a voluntary contributory insurance program for workers — the Community Living Assistance and Social Support (CLASS) Act — to address problems of disability. If you participate and become disabled, you can receive a cash benefit that can be used to build a ramp into your house or hire a home health care aid. While there's obviously a big difference between a voluntary scheme like CLASS and a mandatory payroll tax increase, the legislation at least lays the foundation for self-financed national insurance coverage targeted toward long-term care needs.

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.

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## 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 new legislation 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, which in turn could become federalized as well. 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. It's long past time to discard the fractious mindset and tactics that motivated Wilbur Mills, and act boldly by pursuing one of Ronald Reagan's best ideas.

*Greg Anrig, vice president of policy and programs at The Century Foundation, is the author of "The Conservatives Have No Clothes: Why Right-Wing Ideas Keep Failing."*

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## Endnotes

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<sup>1</sup> Text available at:

[http://www.healthcarelawsuit.us/webfiles.nsf/WF/MRAY-83TKWB/\\$file/HealthCareReformLawsuit.pdf](http://www.healthcarelawsuit.us/webfiles.nsf/WF/MRAY-83TKWB/$file/HealthCareReformLawsuit.pdf)

<sup>2</sup> Memo from Richard S. Foster, chief actuary of the Centers for Medicare and Medicaid Services, on Estimated Financial Effects of the Patient Protection and Affordable Care Act, April 22, 2010, p.3; available at:

[http://republicans.waysandmeans.house.gov/UploadedFiles/OACT\\_Memorandum\\_on\\_Financial\\_Impact\\_of\\_PPACA\\_as\\_Enacted.pdf](http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf)

<sup>3</sup> January Angeles and Matthew Broaddus, “Federal Government Will Pick Up Nearly All the Costs of Health Reform’s Medicaid Expansion,” Center on Budget and Policy Priorities, April 20, 2010; available at:

<http://www.cbpp.org/files/4-20-10health2.pdf>

<sup>4</sup> See Greg Anrig, “Federalism and Its Discontents,” *Democracy*, Winter 2010; available at:

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<sup>5</sup> Timothy Conlan, *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform*, Washington: The Brookings Institution, 1998, p. 5.

<sup>6</sup> David G. Smith and Judith D. Moore, *Medicaid Politics and Policy: 1965-2007*, New Brunswick and London; Transaction Publishers, 2008, pp. 42-3.

<sup>7</sup> Martha Heberlein, Jocelyn Guyer, and Robin Rudowitz, “Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and the States,” The Henry J. Kaiser Family Foundation, May 2010, pp. 3-4; available at

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<sup>10</sup> “Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid’s Reach under Health Care Reform,” The Kaiser Commission on Medicaid and the Uninsured, April 2010

<sup>11</sup> “The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession,” The Kaiser Commission on Medicaid and the Uninsured, September 2009, p. 30; available at: <http://www.kff.org/medicaid/upload/7985.pdf>

<sup>12</sup> Peter Cunningham and Jessica May, “Medicaid Patients Increasingly Concentrated Among Physicians,” Center for Studying Health System Change, Results from the Community Tracking Study, No. 16, August 2006; available at: <http://www.hschange.com/CONTENT/866/866.pdf>

<sup>13</sup> Courtney Burke, “New York’s Health Care Spending: Getting What We Pay For?” The Nelson A. Rockefeller Institute of Government, March 2010; available at: [http://www.rockinst.org/observations/burkec/2010-03-medicaid\\_value.aspx](http://www.rockinst.org/observations/burkec/2010-03-medicaid_value.aspx)

<sup>14</sup> Clare Ansberry, “Disabled Face Hard Choices as States Slash Medicaid,” The Wall Street Journal, May 20, 2010.

<sup>15</sup> “State and Local Governments’ Fiscal Outlook,” Government Accountability Office, March 2010 update, p. 8; available at: <http://www.gao.gov/new.items/d10358.pdf>

<sup>16</sup> Kaiser Commission on Medicaid and the Uninsured, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” February 2009; available at: [http://www.kff.org/medicaid/upload/4091\\_06.pdf](http://www.kff.org/medicaid/upload/4091_06.pdf)

<sup>17</sup> Diane Justice, “Long Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act,” State Health Policy Briefing, National Academy for State Health Policy, April 2010; available at:

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Phone 202 986 2700  
Fax 202 986 3696

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