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Why States Are So Miffed about Medicaid — Economics, Politics, and the "Woodwork Effect"

Benjamin D. Sommers, M.D., Ph.D., and Arnold M. Epstein, M.D.

Medicaid is under attack. During the past 6 months, various U.S. politicians have proposed radical restructuring, spending cuts, and even the outright elimination of the program.

House Republicans have recommended converting the traditional entitlement program for low-income families and the disabled into block grants for states or private vouchers, and they have also declared their goal of repealing the large Medicaid expansion slated for 2014 under the Affordable Care Act (ACA).

There has been even more activity — and vitriol — at the state level. Arizona plans to cut nearly 300,000 adults from its Medicaid rolls over the next year, Florida's legislature voted to shift all Medicaid enrollees into private managed-care plans to reduce costs, and Texas Governor Rick Perry went so far as to suggest that his state might be better off opting out of Medicaid entirely.[1]

In part, state leaders are so riled up about Medicaid because state budgets are in dire straits. But the ACA requires the federal government to pay nearly the full cost of the Medicaid expansion (100% initially and 90% after 2019), and without this expansion millions of uninsured Americans would receive care from public clinics and hospitals that are subsidized by state dollars. So isn't the Medicaid expansion a winning proposition for states?

There is of course more to the story. Although states will receive a large infusion of federal dollars under the ACA, other less-publicized features of the legislation render Medicaid a looming fiscal threat and administrative challenge. In combination with political considerations, these factors have made Medicaid the perfect ideological punching bag for conservatives.

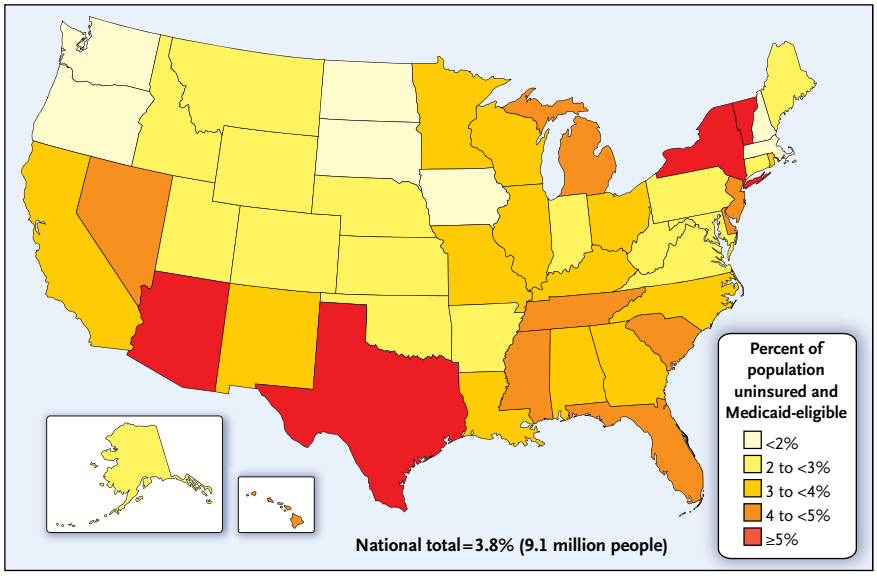
Much of the current debate stems from budgetary difficulties. Medicaid is a joint federal–state program. As of 2009, it accounted for 21% of state spending nationwide, but the federal government foots roughly 60% of the bill. When federal dollars are excluded, Medicaid consumes 12% of state-generated revenues — a proportion that is second only to that of state spending on education.[2] Furthermore, Medicaid is designed to be "countercyclical": enrollment and spending increase when the economy is poor, because more people cannot afford insurance and have incomes low enough to make them eligible for the program. Thus, a recession deals states a double whammy: reduced tax revenue and increased Medicaid spending. It is no coincidence that states' concerns about Medicaid have peaked during a 3-year downturn in the national economy. Often lost in the current discussions is the fact that economists generally view countercyclical government spending as a good thing, because it protects household income and promotes consumption that fuels economic recovery.

Exacerbating the budget problems are several legislative nuances that have attracted little attention outside policy circles. First, the federal government had been providing a higher percentage of Medicaid funds to states as part of the economic stimulus package, but this "enhanced match" expired in June 2011. Second, the ACA includes two potential budget-busting provisions for states.

As of 2014, it expands Medicaid eligibility to people with incomes up to 133% of the federal poverty level. A "Maintenance of Effort" rule in the legislation prohibits states from tightening their eligibility criteria before that time. Thus, states must manage difficult budget shortfalls at a time when the enhanced matching rate for federal funding is expiring, but the easiest way to save money — cutting people from the rolls — is simply not allowed. (The enrollment cut in Arizona is a unique case, because the state is simply choosing not to renew a special waiver program that will expire later this year.)

The other large wrinkle in the ACA relates to what happens to people who are already eligible for Medicaid under current law but are not enrolled. Whereas federal funds cover 100% of costs for newly eligible individuals starting in 2014, states receive the traditional federal contribution rate (currently 50 to 75%, depending on the state) for any additional enrollment of people who were already eligible. Millions of low-income Americans are currently eligible for Medicaid but do not participate because of enrollment barriers, poor retention, or lack of information.[3] States anticipate that many such uninsured individuals will come out of the woodwork and sign up for Medicaid under the ACA, thanks to heavy media coverage, streamlined enrollment procedures required by the law, and the

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Percentages of States' Populations 0–64 Years of Age That Are Currently Uninsured and Eligible for Medicaid.

The sample is restricted to U.S. citizens. Individuals who are theoretically eligible for Medicaid as part of a Section 1115 waiver but who live in states that have closed enrollment owing to legislative caps are not included. Map is based on the authors' analysis of data from the Current Population Survey, 2008–2010. (Further details on Medicaid eligibility criteria used for this analysis can be found in Sommers and Epstein.[3])

individual mandate to obtain insurance.

The map, which is based on our analysis of the Census Bureau's Current Population Survey for 2008 through 2010, shows the possible impact of this phenomenon. In some states, 5 to 8% of the entire population under age 65 are uninsured despite being Medicaid-eligible. Nationally, this "woodwork effect" could draw out more than 9 million uninsured adults and children, including 1.1 million in California, 1.0 million in Texas, and 900,000 in New York. Although only a portion of these people are likely to enroll in Medicaid, adding them to the program's rolls would nonetheless cost states billions of dollars in increased spending. Most affected would be states that currently have generous eligibility criteria for Medicaid, lower participation rates, a higher prevalence of low-income uninsured residents, or some combination of these factors.

The fiscal strain that will result from the Medicaid expansion is compounded by other challenges. Enrolling millions of beneficiaries will require revamped administrative procedures. Expanding provider capacity to make care available to new enrollees and taking steps to prevent disruptions in coverage due to short-term income fluctuations[4] will be critical. These concerns pose administrative challenges that already-pressed state governments could do without.

Finally, one would be naive to ignore the politics surrounding these issues. Medicaid makes a convenient target for conservative governors and legislators because it represents many of the ideological right's lightning rods for outrage: federal control, major government spending, a means-tested program that can be seen as rewarding poverty, and now a manifestation of health care reform. Although Democratic governors are also struggling with Medicaid's budget implications and administrative challenges, their rhetoric is markedly different, without any suggestion that their states' disabled and low-income residents would be better off if the program were privatized, overhauled, or dismantled. With a presidential election in 2012 in which health care will play a major role, there is little reason to expect that Medicaid's public image will receive any reprieve before then.

Given all these considerations, are state leaders unjustified in feeling a certain animosity toward Medicaid? They are clearly in a fiscal bind in which Medicaid plays a large role, and several features of the ACA seem to worsen the budgetary outlook. But this perspective may be shortsighted. The federally subsidized expansion of Medicaid will replace outlays for uncompensated care that largely come from other parts of state budgets (state-funded insurance programs, public state and county hospitals, and community health centers), and one expert analysis has shown that states will actually save money — as much as $130 billion over 5 years — under the ACA.[5] Furthermore, the real budget pressure in Medicaid comes from covering the disabled and chronically ill. The ACA's expansion of the program to include primarily nondisabled adults is unlikely to break the bank.

Perhaps more important, if one accepts that a key priority of health care reform is improving access to care among low-income Americans, then these fiscal and administrative issues are challenges to be tackled in accomplishing that critical public health goal. Absent a viable alternative for covering tens of millions of uninsured Americans, dismantling

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Medicaid would make the problem dramatically worse. There are more than 50 million uninsured individuals in the United States, and expanding access for many, if not all, of them will almost certainly require a robust and expanded role for Medicaid.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Medicaid and Access to Health Care — A Proposal for Continued Inaction?

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Since Medicaid was enacted in 1965, its coverage guarantee for millions of the poorest Americans has faced a substantial vacuum in actual access to health care. Multiple factors contribute to this problem: severe shortages of physicians and hospitals in many low-income inner-city and rural communities; low rates of participation in Medicaid among available providers, owing to low payment rates; state administrative practices that drive providers away; and the economic, clinical, educational, and cultural characteristics of Medicaid beneficiaries.[1] Where they are operating, federal programs such as community health centers, federally funded family planning agencies, the National Health Service Corps, local public health agencies, and public and children's hospitals help to mitigate the situation. But thousands of U.S. communities lack such programs, and even where they do exist, they don't address the specialized long-term care needs of beneficiaries with severe disabilities.

For decades, as the access problem festered, successive federal administrations proved either unable or unwilling to act. Congress therefore entered the fray in 1989, enacting legislation that requires participating states to assure that payments to providers are not only consistent with efficiency, economy, and high-quality care, but also "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[2] Ironically, this language was lifted verbatim from an earlier federal regulation that had been allowed to languish on the books.[3]

Congressional intervention did not, however, serve as a wake-up call. For the past 20 years, subsequent administrations have failed to firmly implement the 1989 amendments. No administration has issued regulations that delineate the standards by which access is to be measured, define the methods states must use for such measurement, set forth clear reporting requirements, or specify actions that the federal government will take to reduce or eliminate barriers to access. The federal government lacks a comprehensive body of research evaluating the effects of state policies and practices on access to care, and no administration has ever issued comprehensive recommendations aimed at guiding and encouraging improvements in access. In short, meaningful federal enforcement — through either rulemaking or active engagement and partnership — has been utterly absent.

A serious problem even in good economic times, this extraordinary federal silence has been particularly deafening in the current economic and political climate, when the need for Medicaid has never been greater, the success of health care reform for nearly one quarter of the population rests on successful implementation of a reformed Medicaid program, and states are especially prone to cut Medicaid provider payments because of grim financial conditions.

Not surprisingly, perhaps, given the sustained record of federal inaction, providers and beneficiaries, relying on long-standing Constitutional principles, have turned to the federal courts to halt ongoing state violations of federal law. A series of lawsuits over the past 20 years has challenged states' deficient administration of their obligations to maintain access to care for Med-

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