Medicaid Commission's Recommendations Would Cut Medicaid Spending While Increasing Federal and State Subsidies for Private Coverage

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The Department of Health and Human Services ordered the creation of a Medicaid Commission in 2005, charging it to make "recommendations on options to achieve $10 billion in scorable Medicaid savings over five years while at the same time mak[ing] progress toward meaningful longer-term program changes to better serve beneficiaries."[1] Because of its mandate to suggest means of substantially cutting Medicaid spending, all Democratic members of Congress, most beneficiary-friendly interest groups, and all but two sitting governors boycotted the Commission, which was supposed to have been bipartisan.[2] Thus, the Commission membership was skewed predominantly towards those who favor decreased Medicaid spending and movement towards privatization of the program, even to the detriment of beneficiaries. For example, the only two governors on the Commission were Jeb Bush of Florida and Joseph Manchin of West Virginia, both of whom undertook large-scale and highly controversial Medicaid restructurings in their respective states.[3]

On November 17, 2006, the federal Medicaid Commission released its recommendations. These recommendations break little new ground. The Commission suggests providing federal and state tax incentives to promote the purchase of long term care insurance, private payment, and home-based provision of long term care.[4] It recommends further expanding state flexibility in altering benefit and eligibility structures for different Medicaid populations, and concomitantly reducing certain forms of federal oversight of these matters.[5] It proposes that states offer tax credits or other means for the uninsured to purchase private health insurance plans, to try to prevent them from taking up Medicaid.[6] It promotes the use of health information technology for Medicaid beneficiaries, as well as the mining of data from these records to determine performance measures and program effectiveness.[7] Finally, it recommends putting individuals who are eligible for both Medicare and Medicaid – often the most impoverished and fragile of the elderly and disabled populations – into private managed care plans.[8]

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[1] *See* Medicaid Program; Establishment of the Medicaid Commission and Request for Nominations for Members, 70 Fed. Reg. 29,765, 29,766 (May 24, 2005).
[2] *Id*., Jeffrey Young, *Democrats Eye Changes to State Medicaid Policies*, THE HILL, Nov. 29, 2006, *available at* http://www.hillnews.com/thehill/export/TheHill/Business/112906_young.html.
[3] *See Roster: Medicaid Commission*, available at http://aspe.hhs.gov/medicaid/roster.pdf (last viewed Nov. 29, 2006).
[4] MEDICAID COMMISSION, FINAL RECOMMENDATIONS 1 (2006), http://aspe.hhs.gov/medicaid/nov06/Recommendations.pdf.
[5] *Id*. at 2.
[6] *Id.*
[7] *Id.* at 3 – 5.
[8] *Id.* at 3 – 4.

Its recommendations clearly indicate that the Commission is biased in favor of the individual responsibility for health insurance, and against the public or communal provision of coverage, no matter what the cost. One recommendation, for example, provides that

> Medicaid's core purpose is to serve needy low-income individuals, especially the most vulnerable populations. Therefore, the Commission recommends a study of a new "scaled match" funding formula in which the federal government would reimburse states at an enhanced matching rate for adding lower-income populations to the program, with the match rate scaling back as they expand Medicaid to higher-income populations. Cost neutrality should be considered.[9]

Some states, such as Massachusetts and Vermont, have sought to expand their Medicaid programs to people earning far in excess of the federal eligibility floors, or who otherwise fall outside of mandatory or optional Medicaid populations.[10] While this was once less of an issue, federal policy now constrains states from using waivers based on this section to expand traditional Medicaid with its full panoply of benefits to its entire population or taking other similarly robust steps to expand the program in ways that would require the federal government to spend more funds than it would have had it not granted the waiver.[11] States with new expansion populations often must achieve broader coverage by saving costs in one or more areas while extending an often-reduced set of benefits to those who newly gain coverage. This means that states presently seeking to achieve nearly universal coverage for their residents are limited in their ability to use Medicaid expansions to do so. Yet the Commission's recommendation seeks to limit the federal government's role in such expansions even further by curtailing federal spending on public coverage for the non-poor.[12]

One might argue that this is merely a prudent step to limit expenditure of federal funds to those who need it most. If this were the case, and if revenues were unconscionably scarce, then it might be justifiable. However, the Commission at the same time recommends expanding private, tax-favored means of paying for items such as long term care insurance for the entire population.[13] Tax incentives cost the federal government revenue just as surely as do Medicaid expenditures: in the latter case, tax money is collected and then spent, whereas in the former, the money simply isn't collected. While it may be that providing tax incentives would ultimately result in a net federal savings, it

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[9] *Id*. at 2.

[10] For a discussion of Medicaid eligibility requirements, see generally, e.g., Kaiser Comm'n on Medicaid & the Uninsured, *Who Needs Medicaid?* (2006), http://www.kff.org/medicaid/upload/7496.pdf.

[11] *See* 59 Fed. Reg. 49249, 49250 (1994); Centers for Medicare and Medicaid Services, *Guidelines for States Interested in Applying for a Health Insurance Flexibility and Accountability (HIFA) Demonstration, available at* http://www.cms.hhs.gov/HIFA/02_Guidelines.asp#TopOfPage (last viewed Nov. 30, 2006).

[12] This recommendation, unlike many of the others, would require congressional action for implementation.

[13] MEDICAID COMMISSION, *supra* note 4, at 1 (proposing that the federal government support employer sponsorship of long term care insurance, and that funds in health savings accounts should be able to be used to pay for long-term care.

does not appear that anyone has yet examined this issue in any detail, and thus no conclusion can be reached regarding it. As a further matter, most tax incentives are regressive – they provide a greater benefit to the wealthier rather than to the poorer, and accordingly cost the government more, the wealthier the taxpayer happens to be. Thus, the notion that the Commission is attempting to be protective of the poor through all its recommendations cannot be maintained. It rather appears that the Commission isn't trying to ensure that federal funds are allocated to the poor rather than to the rich, but instead is merely attempting to prevent any further expansion of public insurance.

It is unfortunate that the Commission took an ideological rather than a pragmatic approach to investigating whether federal spending could be reduced while ensuring "better" service for Medicaid beneficiaries. Greater congressional monitoring of administrative changes to Medicaid, in the face of the Committee's recommendations and other matters, is certainly warranted.[14]

December 2006

[14] *See, e.g.*, Young, *supra* note 2.