Platte Institute

policy STUDY

August 2011

Platte INSTITUTE for economic research

Medicaid

The Need for Medicaid Reform Grows Larger After Obamacare

by Brian Blasé and C.L. Gray, M.D.

Table of Contents

Executive Summary

Medicaid Facts

- Nebraska's inflation-adjusted per capita Medicaid spending increased 224 percent over the past two decades, which was nearly twice as fast as the increase in state education spending and over 20 times faster than the increase in state spending on transportation.
- Nebraska's taxpayers pay about 40 percent of the state's Medicaid spending with the federal government paying the remainder. In Nebraska, an extra dollar of Medicaid spending brings in an extra $1.50 in federal support.
- The open-ended federal reimbursement of state Medicaid spending encourages states to grow inefficiently large programs because of the ability to pass costs to federal taxpayers.
- The perverse incentives that encourage Medicaid's unsustainable growth became exacerbated by persistent state bailouts. When state budget situations deteriorated in the past decade, states received a Medicaid bailout in the form of an increased reimbursement. This enabled states to avoid dealing with irresponsible program growth and created a moral hazard problem where states could look to Washington to rescue them if their programs grew too expensive.
- Medicaid's sizeable crowd-out of private coverage (economists estimate it on the magnitude of 80 percent) and the lack of evidence that Medicaid delivers quality care underscores the fact that a substantial amount of public spending on Medicaid could be saved without an adverse impact.
- Low payment rates for providers who serve Medicaid patients result in an access problem for Medicaid recipients and an overuse of emergency care for non-emergency purposes.

Obamacare

- Obamacare's Medicaid expansion will add nearly 100,000 additional Nebraskans to Medicaid at an *annual* cost to taxpayers in Nebraska of around $500 million.
- Obamacare's maintenance of effort (MOE) requirement effectively means that states must limit Medicaid spending by cutting provider payment rates or optional benefits.

Principles of Reform

- Since Medicaid is already too big, the Obamacare Medicaid expansion must be repealed.
- The open-ended reimbursement should be replaced with fixed allotments to the states to provide them the incentive to reform their programs and stop developing schemes to leverage additional federal dollars. This would impose greater discipline on state programs and make future crises less likely. After utilizing its federal allotment, a state would absorb the full cost of additional program spending, so states would form more efficient programs.
- States should consider a premium assistance model, where certain low-income populations are given a voucher to purchase a private health insurance policy that meets their needs and risk preferences. Enrollees would benefit from increased choice of benefit packages and improved access to providers.
- States should structure vouchers on a sliding scale so those with lower income pay less out of pocket.
- States should control eligibility for their Medicaid programs by limiting the program to individuals who genuinely need public assistance.
- The federal government needs to allow states to reduce the asset exemptions that allow many people to game the rules and qualify for taxpayer financed long-term care through Medicaid. States need to impose meaningful income and asset tests and move away from the nursing home bias in Medicaid. States should also increase estate recovery collections.
- States need flexibility from onerous government rules and mandates. Greater state freedom to experiment is not only consistent with federalism, it enables states to be laboratories where they can adopt a variety of policies and learn from each other about what works and what does not work.

The Need for Medicaid Reform Grows Larger After Obamacare

Brian Blasé
C.L. Gray, M.D.

In the wake of Wisconsin's heated battle over collective bargaining rights, state budget shortfalls leapt into the national headlines. Wisconsin needed to close a $3.6 billion gap. California faced a $14 billion shortfall.[1] The $3.1 billion Illinois deficit[2] led to a 66 percent hike in its state income tax. The ledgers of most states across the country told the same story—the states were broke.

With both President Obama's and House Budget Committee Chairman Paul Ryan's (R-WI) recent budget proposals, a second concern captured America's attention—the federal government is broke. The United States debt now exceeds $14.3 trillion. Under President Obama's most recent budget, the Congressional Budget Office (CBO) anticipates the national debt will exceed $20 trillion by 2020, leaving Americans with hundreds of billions of dollars worth of charges to cover interest on this debt each year.[3]

While each of these crises looms ominously enough when viewed separately, few people fully appreciate how Medicaid binds them together. This is because Washington provides an open-ended reimbursement of state Medicaid spending. Washington covers approximately 60 percent of total Medicaid spending in the form of a federal matching formula. This means if the typical state spends $5 billion on Medicaid, the federal government pays approximately $3 billion of the tab. The result is that state Medicaid spending actually drives a large portion of federal spending. This is Medicaid's fatal flaw.

The open-ended reimbursement of Medicaid spending is a primary reason for state budget crises and partially explains the federal government debt crisis. The ability to pass costs to taxpayers in other states has fueled Medicaid's growth to an unsustainable level. State Medicaid spending last year usurped state spending on elementary and secondary education as the biggest item in state budgets. Medicaid now consumes 22 percent of the average state budget. And last year Medicaid spending represented over 8 percent of the federal budget.[4]

This is a system designed to fail. Unless the method by which Washington helps states cover Medicaid expenses is fundamentally changed, Medicaid will not only exacerbate the federal budget crisis, it will likely push some states into bankruptcy.

Nebraska's Medicaid problems, while possibly not as severe as other states, are still significant. Over the past two decades, Nebraska's Medicaid spending has soared from about 10 percent of state spending to around 18 percent of state spending. During this time period, per capita Medicaid spending has grown nearly twice as fast as state spending on education and over 20 times faster that state spending on transportation. Unsustainable enrollment growth made Nebraska increasingly dependent on continued federal support for the program. As the recession hit and more individuals were eligible for Medicaid from previous eligibility expansions, most states looked to Washington for a bailout. Indeed, no state turned down the extra federal assistance.

The bailout came in the form of an increased federal match. For example, as part of the stimulus bill Washington paid for 69 percent of Nebraska's 2009 and 2010 Medicaid expenditures. This meant for every dollar Nebraska spent on Medicaid, Washington sent the state another $2.25. Because Nebraska spent approximately $500 million on Medicaid they received $1.1 billion as a federal match. However, this simply delayed the inevitable day of reckoning. As the overwhelming national debt now forces Washington to trim its budget, the federal government cannot afford to continue to reimburse states at such a large percentage. States must now come to grips with past mistakes that let Medicaid become too big.

For Nebraska, the loss of its "stimulus dollars," starting July 1st, 2011, causes its federal match to drop from 69 percent to 58 percent. This means instead of getting $2.25 for each dollar the state spent on Medicaid last year, Nebraska will receive $1.50 for each dollar it spends on Medicaid this coming year. The result? A massive state budget shortfall.

To compound the problem, the Patient Protection and Affordable Care Act, commonly dubbed "Obamacare," contained a "maintenance of effort" provision that prohibits states from curtailing current eligibility if they are to receive federal dollars. By preventing states from fundamentally restructuring Medicaid, federal guidelines force states to consider slashing already low provider payment rates, thus putting access to care in serious jeopardy.

The solution to this Gordian Knot lies in fundamentally changing the rules:

1) If states received a non-fungible Medicaid block grant from the federal government rather than fungible matching funds, each state would have the *incentive* to reign in Medicaid spending.

2) If states were freed from the myriad federal mandates (such as the "maintenance of effort" clause of the Patient Protection and Affordable Care Act) they would gain the *ability* to run Medicaid efficiently.

Replacing the current federal financing structure with fixed allotments to the states would help save both state and federal budgets. Without this policy change, states will dig further budgetary holes and the federal government will face an increased likelihood of a debt crisis.

On April 15, 2011, the House of Representatives passed significant and much-needed Medicaid reform based on House Budget Chairman Paul Ryan's (R-WI) proposal to get control over federal spending. Recognizing that the nation cannot afford the size of the current Medicaid program, Ryan's proposal repeals the costly Obamacare expansion of Medicaid (estimated at around $100 billion annually).[5] Ryan's Medicaid reform ends the open-ended federal reimbursement of state Medicaid spending and allows states greater flexibility to manage their programs without interference from the federal bureaucracy. Ryan's proposal allows states to experiment with a variety of reform efforts instead of imposing a one-size-fits-all Medicaid program on every state.

Medicaid is now failing because it became too large to efficiently serve the people it was originally intended to serve. This expansion of eligibility also caused a substantial degree of crowd-out, so taxpayer funds are increasingly spent on individuals who could afford private coverage. This diverts resources from the really poor populations on the program. Plus, there is a lack of evidence that states that have expanded Medicaid have had better health outcomes for their poorer populations. For taxpayers and Medicaid recipients, Congress must chart another course. Washington has to give states greater freedom to determine how to provide a health care safety net within a framework that encourages states to be wise stewards of taxpayer dollars.

Table 1: Nebraska State Per Capita Spending Across Categories

	1989	2009	Growth	Growth Rate
Total State Expenditures	$2,654	$5,087	$2.433	64%
Medicaid	$276	$895	$619	224%
Elementary & Secondary Education	$321	$786	$447	139%
Higher Education	$696	$1,155	$459	66%
Transportation	$383	$417	$34	9%
Corrections	$53	$122	$69	130%
Cash Assistance	$72	$31	-$41	-58%
Other	$853	$1,699	$846	99%

Source: State Expenditure Reports between 1990 and 2009 from The National Association of State Budget Officers. The population estimates come from the Census Bureau. Categories shown constitute roughly 65 percent of state spending.

Nebraska's Medicaid Problem

Table 1 shows that over the past two decades Nebraska's per capita state spending has nearly doubled, from around $2,650 to roughly $5,100 (using inflation-adjusted 2009 dollars). Just over a quarter of Nebraska's spending growth is attributable to Medicaid. Nebraska's Medicaid spending increased 224 percent over the past two decades, controlling for inflation and population growth. State spending on Medicaid grew nearly twice as fast as state education spending and over 20 times faster than state spending on transportation.

In 1989, Nebraska's annual per capita Medicaid expenditures was $276 (using inflation-adjusted 2009 dollars); in 2009 Nebraska's annual per capita Medicaid expenditures was $895. In 1989, Nebraska spent only $109 per person (in 2009 dollars) on Medicaid from state revenues with federal taxpayers paying $167. By 2009, those amounts had grown to $372 and $523, up 241 percent and 213 percent respectively. Medicaid now represents about 18 percent of Nebraska's state government spending, almost twice as high as the percentage it was twenty years ago.

Nebraska's taxpayers traditionally pay about 40 percent of the state's Medicaid spending with the federal government paying the remaining 60 percent. In Nebraska, an extra dollar of Medicaid spending brings in an extra $1.50 in federal support. The generous federal reimbursement means that Medicaid is one of the last places Nebraska looks for budget savings because each dollar cut from the program results in a loss of federal funds.

Despite the impact of the federal Medicaid reimbursement, each dollar Nebraska spends on Medicaid is one less dollar that could have been spent elsewhere or returned to taxpayers. Nebraska's spending on transportation has undoubtedly been crowded out from increased spending on Medicaid. The percentage of the Nebraska state budget spent on transportation has declined from 14 percent to 8 percent over the past 20 years. From about 1991 through 2010, state spending on elementary and secondary education as well as post-secondary education has stayed relatively flat as a percentage of Nebraska's spending. Figure 1 shows how the make-up of Nebraska's budget has changed over the past two decades.

Medicaid is in Crisis

Total Medicaid spending soared from $74 billion in 1990 to an estimated $427 billion in 2010. Part of the cost increase was driven by Medicaid crowding out private coverage. The crowd-out literature demonstrates that parents with employer-sponsored insurance often remove their children from their policies and enroll them in Medicaid in order to pay less in premiums. Economists Jonathan Gruber and Kosali Simon estimated crowd-out at 60 percent from expansions of Medicaid and the Children's Health Insurance Program (CHIP) between 1996 and 2002.[6] This means that of 10 individuals who gain Medicaid coverage, about 6 previously have private health insurance.

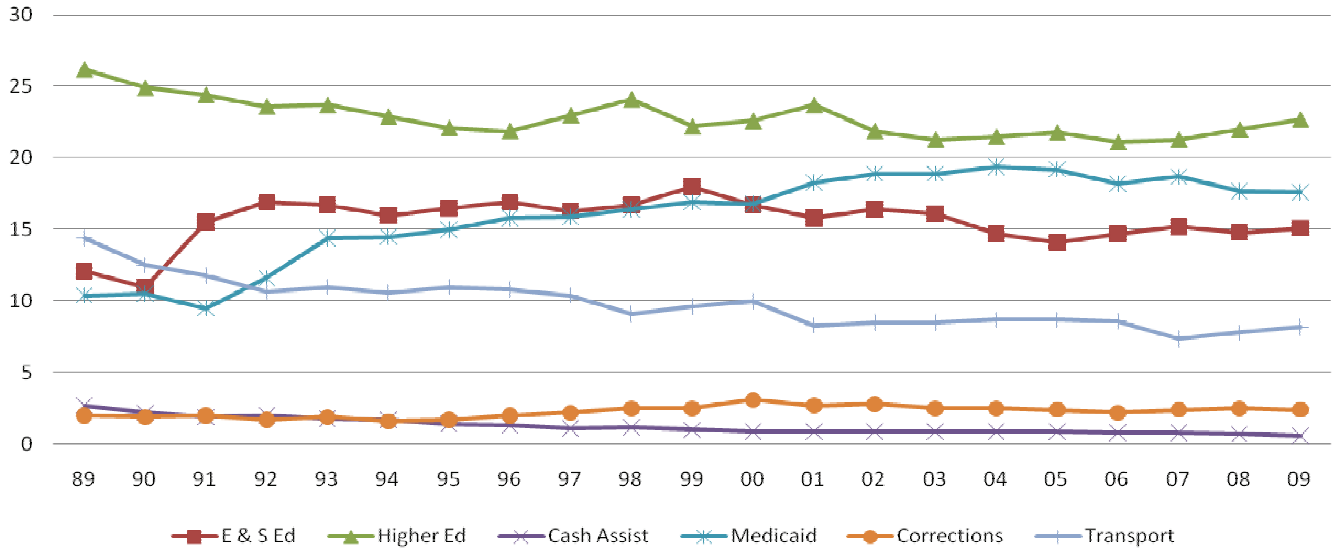
In addition to crowding out private coverage, Medicaid also distorts behavior as individuals try to qualify for the program. If a household earns above the Medicaid eligibility cut-off, they lose this coverage. This aspect of Medicaid policy effectively penalizes these households for hard work and earning additional income. Furthermore, since Medicaid benefits are conditional on having few assets, the program discourages personal saving.

Medicaid also affects behavior in long-term care (LTC) markets since Medicaid reimburses about half of all America's spending on LTC.[7] In fact, LTC now consumes about a third of total Medicaid spending. While there are income and asset requirements for Medicaid LTC eligibility, most states have generous "medical need" income criteria that let applicants deduct health care expenses from their gross income. Given the considerable expense of LTC services, all but very high-income families qualify for Medicaid support.

Generous federal personal asset exemptions also enable many people to qualify for Medicaid LTC without "spending down."[8] In fact, a growing legal industry assists individuals to appear "cash poor" and qualify for Medicaid LTC.[9] Several recent economics studies demonstrate that Medicaid substantially crowds out the purchase of LTC insurance and personal savings.[10] This distortion of the program's original intent significantly drives up costs and further exacerbates state budget problems.

Medicaid's problems are not limited to the demand side; they are also on the supply side. Most states reimburse physicians at extremely low rates, sometimes lower than

Figure 1: Nebraska's State Spending by Category as Percentage of Total State Spending



Source: State Expenditure Reports between 1990 and 2009 from The National Association of State Budget Officers. The population estimates come from the Census Bureau. Categories shown constitute roughly 65 percent of state spending.

one-third of commercial rates. Compounding the problem of low reimbursement, Medicaid requires an inordinate amount of paperwork that drives up doctor's operating costs to the point where many physicians actually lose money treating patients with Medicaid. Furthermore, the lag time between date of service and the date of payment is more than twice as long as Medicare or commercial insurance lag times. Finally, the denial rate for Medicaid claims is three times larger than for both Medicare and commercial insurance.[11] These program features reduce the willingness of doctors to treat patients with Medicaid.

As a result, Medicaid patients are increasingly being seen by a smaller subset of doctors. Of physicians accepting new Medicaid patients, only half get more than 30 percent of their total revenue from Medicaid patients. Additionally, small physician practices are increasingly deciding to not see Medicaid enrollees.[12] *New York Times* health correspondent Robert Pear investigated Medicaid's access problems, and he quoted one woman as saying that "My Medicaid card is useless for me right now. It's a useless piece of plastic. I can't find an orthopedic surgeon or a pain management doctor who will accept Medicaid."[13]

Traditional Medicaid recipients not only have poor access to care, but they tend to have worse outcomes for the care they receive. For example, Medicaid enrollees were more likely to experience complications and in-hospital mortality after surgery for colorectal cancer than both privately insured and uninsured patients.[14] Furthermore, a University of Virginia study of nearly 900,000 major operations in the United States found that surgical patients on Medicaid were 13 percent more likely to die in the hospital than uninsured individuals, controlling for demographic factors and health status.[15] Studies consistently find that Medicaid enrollees spend more time in the hospital recovering and cost more than both the privately insured and the uninsured.

While other factors unique to Medicaid enrollees likely explain a large portion of these results, there is evidence that suggests Medicaid recipients receive different care than other individuals. One study found that Medicaid patients who suffered a heart attack were significantly less likely than patients with other forms of insurance to receive important clinical interventions.[16] Medicaid patients often receive fewer invasive procedures, such as catheterizations, than do privately insured individuals.[17] Additionally, there are many discharge medications, such as aspirin or Beta-blockers, or interventions such as smoking cessation counseling and rehabilitation, which are much less likely to be given to Medicaid recipients.

One explanation for the different care is that private insurance pays more. A second explanation is that cardiologists are more likely than non-cardiologists to use evidence-based therapies to treat heart attacks, and Medicaid patients are less likely to be treated by cardiologists.[18] The poor outcomes for Medicaid recipients may also, in part, be the result of Medicaid's role in creating an environment of helplessness and dependency. This may cause some patients on Medicaid to making fewer good decisions regarding their own health.

Obamacare Worsens the Medicaid Dilemma

Instead of reforming Medicaid to make the program work more efficiently for the people on it, Obamacare expands the failing program and prohibits true reform.

By extending eligibility to every individual below 138 percent of the federal poverty level (FPL), The Office of the Actuary at the Centers for Medicare and Medicaid Services estimates that around 25 million new individuals will enroll in the program.[19] A recent economics paper estimates that the law's expansion will have an 82 percent crowd-out rate for working adults and will "shift workers and their families from private to public insurance without reducing the number of uninsured very much."[20] Doctors are generally skeptical of the expansion, and only 10 percent of primary care physicians (PCPs) believe that new Medicaid enrollees in their area will find a suitable PCP after the expansion.[21]

Obamacare's maintenance of effort (MOE) requirement prohibits states from fundamentally restructuring the program. The MOE requirement prevents states from reducing program eligibility, which means states will be forced to further cut provider payment rates or reduce optional benefits. Given current payment rates are often below the cost of seeing a patient on Medicaid, reducing provider rates further will only serve to exacerbate the access problem and will lead to more individuals seeking care in hospital emergency rooms. In many cases, patients on Medicaid will simply not be able to find a physician willing to deal with the new Medicaid guidelines. Some physicians will respond to payment cuts by up-coding, or billing Medicaid for a service that pays more than the service that was actually provided.

States will have little incentive to control the cost of the expansion, as the federal government has agreed to finance 100 percent of the costs of the expansion population for the first three years (2014-2016). However, when Washington reduces the federal subsidy for these new patients (to 90 percent in outlying years), the expansion will again serve to exacerbate state budget shortfalls. At the same time, it will lead states to disregard the true costs of the expansion as they can pass 90 percent of the cost to Washington. One caveat to this increased subsidy is that individuals who apply for Medicaid and who are eligible under the state eligibility criteria in place on July 1, 2008, will not be reimbursed at the enhanced percentage.[22] Rather, for these individuals in Nebraska, the state will be reimbursed at its standard 58 percent federal medical assistance percentage (FMAP).[23] This means a key variable determining state costs is how many currently eligible individuals will come out of the woodwork to sign up for Medicaid.

Incidentally, the now infamous Cornhusker Kickback engineered by Nebraska Senator Ben Nelson pertained to the federal/state share of the expansion population. In order to secure Senator Nelson's crucial vote for Obamacare, Senate Majority Leader Harry Reid (D-NV) included a provision in the Senate bill that had federal taxpayers picking up 100 percent of the costs of Nebraska's Medicaid expansion. In essence, this would have made Nebraska's Medicaid expansion (except for those individuals who were eligible under previous state criteria) "free" for Nebraska's state taxpayers. When the details emerged from the deal, however, the public backlash against it resulted in its removal from the law.

Nationally, about 12 million individuals are eligible for Medicaid but are not yet enrolled.[24] The individual mandate in Obamacare will serve to push many of them into the program. The bottom line is that Obamacare's Medicaid expansion results in an enormous increase in both federal and state budgets at the very moment when both levels of government are facing a potential debt crisis. Since Obamacare worsens Medicaid's financial outlook without any likely beneficial and discernable improvement in health outcomes, Medicaid reform must begin with repealing Obamacare.

Obamacare's Impact on Nebraska

In Nebraska, Medicaid currently covers approximately 200,000 individuals.[25] Utilizing the national estimates released by the Office of the Actuary at The Center for Medicare and Medicaid Services (CMS), The Heritage Foundation estimated that the PPACA will add nearly 90,000 Nebraskans to the program at a seven-year (2014-2020) cost to state taxpayers of nearly $150 million.[26] Estimates from the Urban Institute based upon their Medicaid model are very similar to Heritage's estimates.[27]

There are several reasons to believe the state-only cost estimates are unrealistically low. Milliman Incorporated, an actuarial and econometric consulting firm, was contracted by several states to perform state-specific analysis of the Medicaid expansion. Milliman has typically estimated an annual increase in state Medicaid costs two to three times greater than both CMS and Urban's estimates. Nebraska's Governor Dave Heineman had Milliman perform an analysis that estimated costs to the state of several multiples of both Heritage's and Urban's estimates. Milliman projects the seven-year cost to Nebraska's state taxpayers of the Medicaid expansion in excess of $500 million and that the expansion will bring in nearly 108,000 individuals into the program by 2014.[28]

Emphasizing the impact on state budgets, however, diverts attention from the true cost of the expansion. While the vast majority of the expansion will be financed by federal dollars, whether the dollars come from Washington or from the state, taxes will increase, which will have a depressing effect on every state's economy. Unless offset by spending cuts, taxes in Nebraska will go up by around $500 million to fund the *annual* $100 billion in new Medicaid spending for the country. Higher taxes combined with the disappointing care that many Medicaid recipients receive should cause state legislators and policymakers in Nebraska to question, if not fight the expansion.

State Medicaid Reform

Commonsense Medicaid reform must occur on two dimensions: financing reform and basic program reforms. Replacing the open-ended federal reimbursement with fixed allotments would discourage states from expanding enrollment to populations that can afford private coverage or that are inappropriate recipients of public assistance. This would likely improve the program for those populations who are genuinely in need of public assistance. Moreover, replacing the current government-centric Medicaid model with a consumer-directed model will likely benefit enrollees and providers.

Scrap the Open-Ended Federal Reimbursement

The open-ended federal reimbursement of state Medicaid spending creates incentives for states to spend carelessly and, in an effort to gain more federal matching funds, to expand the Medicaid program beyond its original mandate. In 2004 Congressional testimony, Kathryn Allen—Director of Health Care for Medicaid and Private Health Insurance Issues—testified that:

> For many years states have used varied financing schemes, sometimes involving IGTs (inter-governmental transfers), to inappropriately increase federal Medicaid matching payments. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, the large payments are often temporary, since states can require the local-government providers to return all or most of the money to the states. States can use these funds—which essentially make a round-trip from the states to the providers and back to the states—at their own discretion.[29]

As an illustration of the problem, Nebraska's traditional FMAP is about 58 percent. This means that the federal government kicks in $580,000 for every $1 million the state spends on a new Medicaid benefit. Nebraska taxpayers only pay $420,000 of the cost. The real cost of the feature is still $1 million, but Nebraska policymakers are rational to pursue the feature so long as the added benefit to the state is at least $360,000. This example illustrates that many Medicaid "benefits" are not worth their corresponding cost. As this example shows, many Medicaid benefits are likely worth less than half the actual cost.

This sets up the classic prisoner's dilemma. If Nebraska policymakers were the only ones to act in this manner, the state would receive a windfall at the expense of taxpayers in

other states. However, every state is tempted by the same incentive. In shaping Medicaid policy, state politicians compare the benefits of expanding Medicaid with only the state costs and not the true costs, which include costs to federal taxpayers. When all 50 states expand their Medicaid programs to attract federal dollars, this drives America even deeper into debt. In the end, American taxpayers are left with a bill that far exceeds the actual benefit of the Medicaid program. This marks the epitome of an economic inefficiency.

Medicaid provider taxes are symptomatic of the lengths states will go toward in order to maximize federal support of their program. These taxes are unique because the payers (hospitals and nursing homes) actually seek to be taxed. This is because the state taxes the Medicaid provider and then spends the original tax revenue on the provider. The state then leverages the amount spent on the provider for extra federal matching funds and bumps up the provider payment out of this extra money. This means the state can increase Medicaid spending solely at the expense of federal, but not state, taxpayers. A major benefit of states receiving fixed allotments for their programs is that they would not have any reason to institute these absurd provider taxes. Moreover, state bureaucracies would have no more incentive to attempt to scheme additional taxpayer money through the federal reimbursement.

Washington's persistent state bailouts further encourage the program's unsustainable growth. Over the past decade, each time state budget situations deteriorated, states received a Medicaid bailout—in the form of an increased FMAP.[30] This enabled states to avoid dealing with irresponsible program growth and created a moral hazard where states looked to Washington to rescue them if their programs grew too expensive.

Medicaid's sizeable crowd-out of private coverage and the lack of evidence that Medicaid delivers quality care underscores the fact that a substantial amount of public spending on Medicaid could be saved without an adverse impact. Putting Medicaid on a fixed budget would not only benefit the American taxpayer, it would provide budget certainty to both the federal and state governments. More importantly, a fixed budget would discourage states from leveraging additional state money to increase their federal Medicaid reimbursement.

This would impose greater discipline on state programs and make future crises less likely. After utilizing its federal allotment, a state would absorb the full cost of additional program spending. Therefore, state policymakers would find a much more efficient level of spending, since additional benefits would be compared to the actual cost of providing them. As an added benefit, states will have a greater incentive to ensure that taxpayer dollars go to individuals who genuinely deserve public assistance. This financing change would also provide states with the incentive to reduce Medicaid fraud, which is estimated in the tens of billions of dollars.

Erskine Bowles and Alan Simpson, the co-chairs of President Obama's Fiscal Commission proposed converting the federal support of Medicaid long-term care (LTC) into a capped allotment. This would create a federal budget for Medicaid, out of which states would receive a fixed sum to finance LTC services. The proposal is estimated to save *federal* taxpayers $89 billion between 2012 and 2020.[31] While the Commission's proposal is a step in the right direction, a fixed allotment should encapsulate acute-care services as well. Alice Rivlin, former director of the Congressional Budget Office (CBO), and Paul Ryan, Chairman of the House Budget Committee (R-WI), have proposed state block grants for the entire Medicaid program. The CBO scored the Ryan-Rivlin proposal to save about $680 billion between 2012 and 2020.[32]

Premium Assistance Model

State Medicaid programs currently pay for health care services that enrollees receive through a one-size-fits-all, fairly comprehensive benefit package. This model is government-centric as state governments choose the benefit package and set provider payment rates. State flexibility is restricted because the federal government limits the premiums and cost-sharing that enrollees are allowed to pay for services. Instead of utilizing market ideas to control costs by allowing recipients to choose from a variety of benefit packages and out-of-pocket payments, states manage program spending through price and quantity controls. This model causes an overutilization of health services and treats Medicaid enrollees (and parents if only children are enrolled) as children who cannot handle basic choices. Moreover, the current program is

unfair to lower income workers without Medicaid coverage who receive less comprehensive health packages, either as part of their employee compensation or from coverage purchased in the non-group market.

States should consider a premium assistance model as an alternative to the current Medicaid model. Under premium assistance, a state would provide certain low-income populations with a voucher that could be used to purchase a private health insurance policy, including employer-based coverage, that meets their needs and risk preferences. Enrollees would benefit from increased choice of benefit packages and improved access to providers. If eligibility is controlled, the bulk of the voucher would likely be financed out of the fixed federal allotment.

The voucher should be structured as a fixed amount with its size depending on household income. For the *lowest* income households, the voucher should be indexed to a certain percentage of the cost of basic health insurance coverage (around 95 percent) that includes both a "free" annual wellness and dental check-up as well as minimal cost-sharing. The voucher could be increased for a pregnant woman by including a pregnancy rider.[33]

The household is free to take the voucher and buy any type of coverage that it wants, but the more comprehensive coverage the more the household will have to pay out-of-pocket. The amount of the voucher should be decreased on a sliding scale as household income rises until such a point that it phases out completely. This type of sliding scale would preserve public funds for those that need them the most and would reduce the implicit marginal tax of losing government benefits as household income increases.[34] Premium assistance introduces a greater sense of cost consciousness among program participants and also greater continuity of coverage, which is a major concern as people tend to transition on and off the program.

States moving toward a premium support model would likely experience administrative savings from reducing the state's role in directly reimbursing providers, verifying claims, and managing the state Medicaid bureaucracy. Moreover, there would likely be efficiency improvements from covering under a single policy all members of a family who are currently covered separately by different combinations of public or private plans.

In the past two decades, most states have attempted to control costs by enrolling many Medicaid recipients into managed care. Under a Medicaid managed care model, the government pays an insurance company a fixed amount per enrollee, and the insurance company is responsible for coordinating that individual's health care. Managed care replaces the fee-for-service model, which encourages providers to over-treat patients. Under the premium support model, individuals would be free to choose from a variety of insurance options, including managed care.

In lieu of premium support or in a transition toward that model, state officials can take several actions to both be good stewards of taxpayers' dollars while encouraging a more appropriate use of care by Medicaid enrollees.

- **Increase enrollee cost-sharing.** Cost-sharing gives program recipients some "skin in the game" and exerts downward pressure on program spending. Cost-sharing should increase when program beneficiaries utilize expensive care settings, such as the emergency room, for non-emergency care needs. Cost-sharing can also be scaled for household income with lower-income families paying a lower amount.
- **Sliding scale for premiums.** The availability of tax dollars is limited, and a sliding scale for premiums would provide greater funds to households that need them more. Households with greater amounts of income would pay a greater portion of the premium. And the sliding scale would reduce perverse behavior that discourages work and productivity at the income threshold where individuals risk losing all program benefits. Moreover, adjusting premiums by household income minimizes the amount of crowd-out for individuals at the top of eligibility thresholds.
- **Manage program eligibility.** Within federal guidelines, states should limit program eligibility to individuals who truly need public assistance. States will want to minimize the crowd-out effect that passes private costs to taxpayers. Eligibility should include a strong income and asset test that is reviewed several times a year to ensure the temporary nature of Medicaid as a safety net program. Additionally, states may also wish to tighten retroactive eligibility.

Reform Medicaid for the Disabled and Elderly

Roughly two-thirds of national Medicaid spending goes to the elderly and disabled, with about half of that amount spent on long-term care (LTC) services.[35] Currently, nursing home coverage is a mandatory benefit under Medicaid, but states need a waiver in order to provide Medicaid-financed services in the home and community. This creates a program bias toward nursing home care. Fortunately, states can take several actions to lower government spending, encourage private financing of LTC, and improve care for individuals receiving Medicaid LTC services.[36]

- **Reduce eligibility exemptions.** Given the federally mandated asset exemptions, qualifying for Medicaid LTC support is not difficult. As discussed (see footnote 9) current federal law allows individuals to exclude most assets and still qualify for Medicaid. Eliminating or reducing these exemptions would lower government spending and better conserve public resources for those who truly need assistance. Moreover, tightening eligibility for LTC will encourage individuals to plan for these types of expenses through savings and the purchase of LTC insurance.
- **Move away from the nursing home model.** The nursing home bias exists even though average nursing home costs far exceed costs for services provided in the home or community. And indeed, most individuals prefer to avoid nursing homes. In an effort to control Medicaid spending, many states have attempted to "rebalance" Medicaid LTC by moving individuals from nursing homes to the home or community. Because of the federal exemptions and loopholes for Medicaid LTC, states that have rebalanced more aggressively have had relatively large increases in Medicaid LTC spending. This is because demand for Medicaid increased when states began paying for services in the home and community. This suggests that controlling eligibility for Medicaid is a necessary first step for rebalancing to lower state Medicaid spending.
- **Increase Estate Recovery Efforts.** The Deficit Reduction Act of 2005 allowed states to look back up to five years on asset transfers and impose penalties on individuals who transferred assets below fair market value for the purpose of qualifying for Medicaid. This is necessary because less than one percent of Medicaid spending on nursing facilities is recovered by state governments.[37] In Nebraska, even less is recovered. In fiscal year 2004, Nebraska spent $360 billion in Medicaid nursing facility expenditures, yet only recovered $1.1 million, less than one-half of 1 percent of payments.[38] Increasing estate recovery would remove a portion of the taxpayer burden for funding LTC expenses. This in turn would encourage LTC insurance via the private market.[39]
- **Improve care coordination.** Care coordination for recipients of LTC services is often lacking. Less than 10 percent of spending for dual-eligible individuals (those with both Medicare and Medicaid) is covered under coordinated care arrangements. The Lewin Group has estimated that states could save around 8 percent of current expenditures by transitioning enrollees with disabilities into managed care.

Getting to Reform

The reforms outlined above represent just a small set of ideas on how to incorporate the principles of limited government into health policy.[40] States currently have the flexibility to make some reforms to their Medicaid programs but the open-ended reimbursement reduces their incentive to do so and the federal bureaucracy is often a great hindrance. States must submit either Medicaid State Plan Amendments or waiver requests to the Centers for Medicare and Medicaid Services in order to make changes to their programs. It is not unusual for requests to take months or even years to navigate the bureaucratic process. The high cost in time and effort and the frustrating delays that state officials encounter dull their enthusiasm to pursue Medicaid reform. This is why financing reform must be coupled with measures that increase state's flexibility to design and run their programs. Greater state freedom to experiment is consistent with federalism but it also enables states to be laboratories where they can adopt a variety of policies and learn from each other about what works and what does not work.

Trade Money for Flexibility

States are wise to consider trading the open-ended reimbursement of Medicaid spending, which creates long-

term fiscal headaches for states, for the flexibility to better manage their programs. In early 2009, Rhode Island received a Global Waiver for operating its Medicaid program. Rhode Island is still under the traditional FMAP reimbursement structure, but it agreed to a budget cap as part of the waiver. While Rhode Island's Global Waiver is a promising start, the budget cap was set too high for it to impose meaningful discipline on the state program. Additionally, CMS granted Rhode Island only a modicum of additional flexibility. The waiver, however, does give Rhode Island greater freedom to change aspects of its program. If Rhode Island submits a program change to CMS and does not hear back within 45 days, the change is deemed approved (at least until CMS does respond).

Since there is an urgent need to trim the federal budget, Congress would be wise to offer states increased flexibility in exchange for agreeing to replace the open-ended reimbursement with fixed allotments set closer to pre-recession federal spending levels. Of course, the first key element of such an arrangement for states is the ability to make changes to their programs without seeking approval from the federal bureaucracy. There are three additional areas where states need increased flexibility now. First, states need the flexibility to decide which populations in the state most urgently need taxpayer support. Second, states need the flexibility to eliminate federal exemptions and loopholes for Medicaid long-term care (LTC). Third, states need the flexibility to opt out of the Obamacare Medicaid expansion.

Obamacare should be repealed. But, while that effort is underway, states cannot tighten Medicaid eligibility if the maintenance of effort (MOE) requirement in Obamacare stays in place. Many states cannot reduce provider payment rates much further if they want Medicaid enrollees to have anything other than access to emergency rooms. Further cuts to provider payments might also face legal challenges. For example, providers in the state of California successfully received an injunction of a proposal to cut Medicaid payment rates 10 percent.[41] The providers presented evidence that the cuts would lead to an exodus of providers serving Medicaid patients. This case will be decided by the Supreme Court and will have major ramifications for state Medicaid programs.[42] States can further cut Medicaid benefits, but they are unlikely to save nearly enough money—without touching eligibility or fundamentally restructuring the program—to avoid crippling tax increases or major cuts in other state priorities.

In January, all 29 Republican governors sent a letter to the White House and Congress asking for the MOE requirement in the PPACA to be repealed. "States are unable to afford the current Medicaid program, yet our hands are tied by the maintenance of effort requirements," the governors wrote. "The effect of the federal requirements is unconscionable; the federal requirements force governors to cut other critical state programs, such as education, in order to fund a 'one-size-fits-all' approach to Medicaid. Again, we ask you to lift the MOE requirements so that states may make difficult budget decisions in ways that reflect the needs of their residents."[43]

Although the letter was signed by only Republicans, Medicaid is generally a greater problem in more liberal states, which tend to have more expansive programs. For example, the new governor of New York, Andrew Cuomo, has proposed cutting $4 billion of projected spending on Medicaid (this savings will be split between the state and the federal government) to help close a $10 billion budget gap.[44] Most New York taxpayers would greatly benefit from the state limiting federal exemptions for Medicaid LTC. If states get this flexibility, then they can tailor their programs to their own preferences and can experiment with policy improvements that lower spending.

Roadmap for Nebraska's Legislature

Several states have suggested the idea of opting out of Medicaid given the enormous pressure the program has placed on state finances. Indeed, Medicaid is a voluntary program for the states. The reason all states participate in Medicaid is the size of the federal contribution to state spending. Texas seemed to be very serious about opting out of Medicaid, but the state conducted a study that concluded opting out would not be a viable solution.[45] This is because of the lost federal match for Medicaid spending, which is essentially the federal taxes paid by Texas households that come back to the state in the form of the federal Medicaid contribution. The conclusion is that while states would gain flexibility from opting out of Medicaid, they would lose an enormous amount of revenue. And the trade-off for states does not appear to be a realistic one.

The most important action states can now undertake is to challenge the structural framework of the program. The open-ended federal reimbursement is the main driver of problems in the program. State legislators in Nebraska need to be supportive of efforts at the federal level to replace the current financing structure with a system of fixed federal allotments to the states. Given the notoriety of the "Cornhusker Kickback", this problem should be more apparent in Nebraska than in most other states in the country. Moreover, state legislators in Nebraska should be supportive of efforts to repeal the Obamacare Medicaid expansion. To achieve these policy reforms, Nebraska legislators should join, if not lead, a coalition of other states to press Washington for the fundamental Medicaid reform discussed in this paper.

Beyond efforts at the federal level, state legislators should pursue several of the options discussed in the paper to improve the cost-effectiveness of their Medicaid programs. The Deficit Reduction Act (DRA) of 2005 allowed states to enact limited reforms in their programs, such as increasing premiums and cost-sharing amounts for certain groups and increasing the look-back period for estate recoveries. Nebraska legislators should assess the flexibility allowed in DRA and pursue commonsense reforms in their programs while working toward a more consumer-directed model of health care for lower income populations.

Conclusion

Medicaid needs to be fundamentally reformed because it is failing both current enrollees and taxpayers. Although taxpayers spend 3 percent of total national income (gross domestic product) on Medicaid,[46] there is a lack of academic studies showing that the program provides recipients with quality health care. The observational studies show that uninsured individuals often have better outcomes than individuals with Medicaid, even after controlling for the kind of surgical procedure performed and characteristics of the patients and hospitals.[47] In many areas of the country, Medicaid cards already represent little more than a worthless piece of plastic.

States can improve care for genuinely deserving populations while simultaneously reducing Medicaid spending. The reason is that Medicaid has grown too large to serve those individuals who would most benefit from the public assistance. The key takeaway from a fair reading of the research on the quality of Medicaid is that carefully targeted public assistance can have a beneficial impact, but that broad eligibility expansions likely do more harm than good when all the effects, including crowd-out and budget shortfalls, are considered. And the open-ended federal reimbursement of state Medicaid spending is largely to blame for the irresponsible growth in program eligibility.

The reforms laid out in this paper are a central component of Congressman Ryan's Medicaid component of the budget proposal that passed the House of Representatives. If his proposal becomes law, states will be encouraged to target taxpayer assistance to those most in need and give recipients incentives to become more cost-conscious consumers, preserving the program for those who need it the most in the future. This seems both more practical and more humane than expanding the program at great expense to taxpayers and imposing cost and quantity controls on recipients with the side effect of a low quality of care for many program recipients.

About the Authors

Brian Blasé is a former policy analyst in Health Studies at The Heritage Foundation in Washington, D.C. Blase is an expert in health economics, with a particular focus on Medicaid and long-term care issues. He is currently a doctoral candidate in economics at George Mason University and he teaches a course in Economics and Public Policy at Georgetown University.

Dr. C. L. Gray is a nationally known writer, speaker, and board certified physician practicing hospital-based medicine in western North Carolina. In 2006, he founded Physicians for Reform, a non-profit organization dedicated to preserving fiscally responsible, patient-centered healthcare. Gray's current book, *The Battle for America's Soul*, resulted from a decade spent in research and analysis of the history and philosophy of medical ethics. His book presents findings that link America's present cultural divide with the practice of Post-Hippocratic medicine.

Endnotes

1 State Budget Solutions, April 26, 2011, http://www.statebudgetsolutions.org

2 Institute for Illinois' Fiscal Sustainability at the Civic Federation, March 24, 2011, http://www.civicfed.org/iifs/blog/state-deficit-expected-decline-fy2011-due-tax-increases-and-borrowing

3 Letter to Chairman of The Senate Committee on Appropriation Daniel Inouye from Douglas Elmendorf, Director of the Congressional Budget Office, March 18, 2001 at http://www.cbo.gov/ftpdocs/121xx/doc12103/2011-03-18-APB-PreliminaryReport.pdf (April 27, 2011).

4 U.S. Government Printing Office, http://www.gpoaccess.gov/usbudget/fy10/pdf/budget/summary.pdf

5 Cost estimates to federal taxpayers for the Medicaid expansion according to the Congressional Budget Office are $56 billion in FY 2015, $81 billion in FY 2016, $87 billion in FY 2017, $91 billion in FY 2018, and $97 billion in FY 2019. The Centers for Medicare and Medicaid Services estimates are $63 billion in FY 2015, $79 billion in FY 2016, $72 billion in FY 2017, $76 billion in FY 2018, and $81 billion in FY 2019. These estimates do not include the costs to state taxpayers. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf (June 22, 2010); Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (July 21, 2010).

6 Jonathan Gruber and Kosali Simon, "Crowd-out 10 years later: Have recent public insurance expansions crowded out private health insurance?," Journal of Health Economics, Vol. 27 (2008), p. 201-17.

7 Harriet Kosimar and Lee Shirley Thompson, "National Spending for Long-Term Care," Georgetown University, Long-Term Care Financing Project, February 2006, at http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf (July 21, 2010).

8 Current law allows individuals to exclude certain assets to qualify for Medicaid: a home and all contiguous property with up to $500,000 in equity (or in some states $750,000), household goods regardless of value, one business including the capital and cash flow of unlimited value, retirement funds such as Individual Retirement Accounts up to $500,000, one automobile of unlimited value, unlimited prepaid burial plans for the Medicaid recipient and immediate family members, and an unlimited amount of term-life insurance.

9 The top two results and seven of the top 10 results when searching for "Medicaid" in the books section on Amazon.com are books promoting Medicaid planning techniques. The first book appearing as of January 21, 2011, is How to Protect Your Family's Assets from Devastating Nursing Home Costs: Medicaid Secrets. Here is a portion of the product description: "Written by an elder law attorney with over 25 years experience, this book will help anyone with a family member faced with a long-term stay in a nursing home who wishes to preserve at least some of their assets by qualifying for the Medicaid program. You don't have to be broke to qualify! … The book includes tips on: how to title your home so you do not lose it to the state; how to make transfers to family members that won't disqualify you from Medicaid; how annuities make assets "disappear"; smart tricks for "spending down" your assets; what to change in your will to save thousands of dollars if your spouse ever needs nursing home care; avoiding the state's reimbursement claim following the nursing home resident's death."

10 Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," American Economic Review, Vol. 98, No.3 (2008), pp. 1083—1102; Geena Kim, "Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment," 12th Annual Joint Conference of the Retirement Research Consortium, 2010.

11 AthenaHealth, "PayerView 2010: Improving the Way Providers and Payers Work Together," May 2010, at http://www.athenahealth.com/_doc/pdf/whitepapers/PayerView_Whitepaper_2010_Final.pdf (September 29, 2010).

12 Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Health System Change, August 2006, at http://hschange.org/CONTENT/866/ (April 7, 2011).

13 Robert Pear, "Cuts Leave Patients with Medicaid Cards, but No Specialist to See," New York Times, April 1, 2011 accessed at http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html?ref=robertpear (April 5, 2011).

14 R. R. Kelz et al., "Morbidity and mortality of colorectal carcinoma surgery differs by insurance status," Cancer, Vol. 101, Issue 10 (2004), pp. 2187-2194.

15 D. J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," Annals of Surgery, Vol. 252, Issue 3 (2010), pp. 544-551.

16 E. F. Philibin et al., "Underuse of Invasive Procedures Among Medicaid Patients With Acute Myocardial Infarction," American Journal of Public Health, Vol. 91, No. 7 (2001), pp. 1082-1088.

17 J .E. Calvin et al., "Insurance Coverage and Care of Patients with Non-ST-Segment Elevation Acute Coronary Syndromes," Annals of Internal Medicine, Vol. 145, No. 10 (2006), pp. 739-748.

18 Ibid.

19 Obamacare mandates states enroll every applicant in a household at less than 138 percent of the federal poverty level into the program. The chief Actuary, Rick Foster, at the Centers for Medicare and Medicaid Services recently updated earlier estimates from approximately 20 million to 24.7 million on March 30, 2011 in testimony before the House Energy and Commerce Committee.

20 Steven D. Pizer, Austin B. Frakt, and Lisa I. Iezzoni, "The Effect of Health Reform on Public and Private Insurance in the Long Run," (March 9, 2011). Available at SSRN: http://ssrn.com/abstract=1782210

21 Doug Trapp, "New Medicaid Patients Will Lack Access, Most Doctors Say," Amednews.com, May 3, 2010, at http://www.ama-assn.org/amednews/2010/05/03/gvsb0503.htm (September 30, 2010).

22 John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL," Kaiser Family Foundation Commission on Medicaid and the Uninsured, May 2010, p. 6, at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf (November 17, 2010).

23

24 Julie Schoenman, Nancy Chockley, and Brigid Murphy, "Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations," National Institute for Health Care Management Foundation Issue Brief, April 2008, at http://www.nihcm.org/pdf/NIHCM-Uninsured-Final.pdf (November 17, 2010).

25 Kaiser Family Foundation, Trends in Medicaid Enrollment, June 2010, http://www.statehealthfacts.org/comparetable.jsp?ind=794&cat=4&sub=52&yr=207&typ=1&sort=a (April 27, 2011)

26 These figures do not include the federal reimbursement. Ed Haislmaier and Brian Blase, "PPACA: Impact on States," Heritage Foundation Backgrounder No. 2433, July 1, 2010, at http://www.heritage.org/Research/Reports/2010/07/PPACA-Impact-on-States (November 18, 2010).

27 633,000 under the standard participation scenario and 888,000 under the enhanced participation scenario. The corresponding state costs for the six-year period between 2014 and 2019 are $1.03 billion and $1.79 billion, respectively. The standard scenario is one where 3 percent of those currently uninsured who qualify for Medicaid will enroll and 57 percent of the current uninsured who are new eligible enroll. The comparative figures for the enhanced scenario are 40 percent and 75 percent. There are also varying assumptions based on individuals with ESI or non-group coverage and whether they replace coverage with Medicaid. Holahan and Headen, "Medicaid Coverage and Spending in Health Reform," pp. 10-11.

28 Milliman Inc. Letter to Vivianne Chaumont, Director of Division of Medicaid and Long-Term Care for the Department of Health and Human Services in Nebraska Re: Patient Protection and Affordable Care Act With House Reconciliation—Financial Analysis," August 16, 2010 at http://www.governor.nebraska.gov/news/2010/08/pdf/Nebraska%20Medicaid%20PPACA%20Fiscal%20Impact.pdf (May 4, 2011).

29 Kathryn Allen, Director of Health Care—Medicaid and Private Health Insurance, "Intergovernmental Transfers Have Facilitated State Financing Schemes," March 18, 2004 testimony before the Subcommittee on Health—Committee on Energy and Commerce.

30 States received a slightly enhanced FMAP in 2003/2004 and a substantial FMAP increase beginning in July 1, 2008 that is set to expire on June 30 2011. The bailout in the later period was supposed to expire on December 31, 2010 but it was extended through June 30, 2011 in the summer of 2010.

31 Co-Chairs of National Commission on Fiscal Responsibility and Reform Proposal, November 10, 2010, at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair_Draft.pdf (April 11, 2011).

32 CBO scored the Ryan-Rivlin block grant proposal to save $180 billion from Medicaid with the repeal of Obamacare to save another $500 billion. Letter to Congressman Ryan, Preliminary Analysis of the Ryan-Rivlin Health Care Proposal, November 17, 2010 at http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf (April 11, 2011).

33 An insurance rider provides the policyholder extra protection beyond the provisions contained in a standard insurance agreement.

34 For a discussion of the implications of this, please see Daniel Kessler, "How Health Reform Punishes Work," Wall Street Journal, April 25, 2011 at http://online.wsj.com/article/SB10001424052748704628404576265692304582936.html (April 26, 2011).

35 See StateHealthFacts.org, "Distribution of Medicaid Spending by Service, FY2009," at http://www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4, and "Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007," at http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4 (February 24, 2011).

36 For an in depth analysis of Nebraska's long-term care problem, please see Stephen Moses, "The Heartland Model for Long-Term Care Reform," Center for Long-Term Care Financing, December 1, 2003 at http://www.johnlocke.org/research/show/policy%20reports/145 (April 27, 2011).

37 Julie Stone-Axelrad, "Medicaid Asset Transfers and Estate Planning Testimony Before the Senate Committee on Finance," Congressional Research Service, June 29, 2005.

38 Julie Stone, "Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery," Congressional Research Service, January 31, 2008.

39 UnitedHealth Center for Health Reform and Modernization, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid," April 2010, p. 26, at http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf (February 25, 2011).

40 The Buckeye Institute published "Reforming Medicaid in Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes" and would be of interest for readers who are interested in a comprehensive list of ideas for reforming Medicaid. The report is available in PDF format at http://www.buckeyeinstitute.org/reports.

41 Michael Doyle, "Supreme Court takes on states' plans to cut Medicaid payments," McClatchy Newspapers, January 18, 2011 at http://www.mcclatchydc.com/2011/01/18/107002/supreme-court-takes-on-states.html (April 11, 2011).

42 The case, Maxwell-Jolly v. Independent Living Center of Southern California, revolves around the issue of whether state authorities have the right to reduce Medicaid reimbursements even though federal law states that payments must be "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available ... to the general population."

43 The maintenance-of-effort requirements in the health care law indicate that a state could lose all of its federal Medicaid support if it drops out of the program. Republican Governors Association, "GOP Governors Ask Feds to Ease Healthcare Mandates," January 7, 2011 at http://www.rga.org/homepage/gop-governors-ask-feds-to-ease-healthcare-mandates/ (February 23, 2011).

44 Jacob Gershman, "Cuomo Targeting Medicaid Spending," Wall Street Journal, January 4, 2011 at http://online.wsj.com/article/SB10001424052748704111504576060280154691892.html (April 11, 2011).

45 Texas Health and Human Services Commission, "Impact on Texas if Medicaid is eliminated," December 2010 at http://static.texastribune.org/media/documents/Impact_on_Texas_if_Medicaid_is_Eliminated.pdf (May 3, 2011).

The Platte Institute for Economic Research: Leading the Way

Our Mission: Advance public policy alternatives that foster limited government, personal responsibility and free enterprise in Nebraska. By conducting vital research and publishing timely reports, briefings, and other material, the Platte Institute will assist policy makers, the media and the general public in gaining insight to time-proven free market ideas.

Platte Institute Board of Directors:

Pete Ricketts
Director and President of Platte Institute. He is the founder of Drakon, LLC, an asset management company in Omaha, Nebraska. He is also a member of the TD Ameritrade Board of Directors.

Gail Werner-Robertson
Director and prominent Omaha businesswoman and philanthropist.

Warren Arganbright
Director and noted north central Nebraska lawyer and water resources activist. He has practiced through-out Nebraska and South Dakota and has represented the Niobrara Council since its creation.

Michael Groene
Director and farm equipment sales representative. He is co-founder of the Western Nebraska Taxpayers Association.

Travis Hiner
Former president and chairman of Hiner Implement, Inc., and president/chairman of Hiner Lease Company. He has served as a board member of the Kosman Banking Family since 1990 (now Platte Valley Companies).

Executive Director:

John S. McCollister
He recently capped a 35 year career with McCollister & Co. and served five terms on the publically elected Metropolitan Utilities District Board of Directors.

Platte INSTITUTE *for economic research*

900 South 74th Plaza
Suite 400
Omaha, NE 68114
402.452.3737
www.platteinstitute.org

A non-profit foundation, the Platte Institute relies on the resources and innovative thinking of individuals who share a commitment to liberty and the best possible quality of life for Nebraskans.

www.platteinstitute.org