

Medicaid Reform: Economic Independence VS. Government Dependency

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Abstract: Over the last fifty-three years, since the conception of the Medicaid program, government spending has risen at proliferative rates, resulting in economic turmoil and continues to breed government dependency. Key components have contributed to this disposition including massive increases to enrollment of the program, costly compliance violations, and the inability to properly reform the Medicaid system. Renovation of the Medicaid program is essential, and can only be done if all parties accept accountability respectively.

Medicaid History & Evolution

Since the introduction of the Medicaid system, on July 30, 1965, by President Lyndon Johnson, the program has grown exponentially and impacted the amount of government spending to an all-time high. When the Medicaid program began, government spending was reported to be \$10,075,000 dollars in 1965.¹ Most recently, in 2016, government Medicaid spending was reported at \$553,453,647,756 dollars.² This spike in spending represents an astounding 5,493,236% increase since the program was created. Since its conception, the Medicaid program has undergone drastic changes, and demonstrates a growing dependency of the American people on government provided health care. Factors which have contributed to this enormous increase include: lenient eligibility requirements, faulty compliance programs and the lack of proper Medicaid reform. Medicaid reform has now become essential to decrease government spending, ensure compliance measures are met, and to assist Americans in gaining financial independence while decreasing government dependency to avoid further economic drain.

The United States Medicaid program was initially created as a jointly funded federal-state program, which provides healthcare to low or no income Americans.³ Its sole purpose is to provide comprehensive medical care for Americans who need it the most, but do not have the resources to gain access to healthcare.⁴ The Medicaid program provides coverage to all disabled Americans, the elderly, and guarantees that all pregnant woman and children are medically insured.³ Though states were held to specific federal requirements such as “eligibility, level of services provided, and health care provider payments”; states were expected to build their own unique Medicaid programs which would best assist the citizens in their state.³ The partnership afforded states, financial support that would match a portion of the costs, reimbursing each state for some of the costs that were incurred.³ “The federal matching percentage share of total Medicaid expenditures, known as the FMAP, has varied (from approximately 50% to 85%) based each state’s average per capita income level.”⁵

¹ Rice, Dorothy P. & Cooper, Barbara S. National Health Expenditures, 1950-1967. Social Security Administration. <https://www.ssa.gov/policy/docs/ssb/v32n1/v32n1p3.pdf>.

² Total Medicaid Spending FY2016. Henry J. Kaiser Family Foundation. <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³ The Honorable Bob Graham. Medicaid Reform: Saving An American Success Story. 1996. Westlaw. 51 Soc.Sec.Rep.Serv. 979.

⁴ Hermer, Laura D. Federal/State Tensions In Fulfilling Medicaid’s Purpose. 2012. Westlaw. 21 Annals Health L. 615.

⁵ Fishman, Eliot., Mill, Windsor., Gallant Cozen, Mark H., O’Connor, PC. Medicaid Expansion and Regulatory Developments Affecting Provider Reimbursement. April 13, 2016. Westlaw. 20160413 AHLA Siminar Papers 7.

Over the years, states have experienced large increases in Medicaid enrollment.⁶ Enrollment numbers have sky rocketed during the recent recession in the United States which forced people out of their jobs and left them without employer-based insurance benefits.⁶ “As Americans lost employer-based insurance due to the recession, and others became eligible for Medicaid benefits, reliance on the country’s safety-net health care system increased considerably.”⁶ Due to these increases in enrollment, many states have become dependent on the federalist relationship that provides the financial support to their Medicaid budgets.⁶ Many states, specifically Minnesota, California, Arizona and Florida, are faced with billion dollar budget deficits.⁶ These deficits are forcing states to make massive budget cuts to Medicaid spending in attempt to rectify the deficits that they are facing.⁶ Commonly, when states face significant budget deficits, Medicaid is the first area to take a cut.⁶ This is necessary because federal and state budgets were not designed to sustain the healthcare needs of the people. While supporting citizens during difficult times should come from our government budgets, the support should be used as a hand up not a hand out. Ultimately, individuals must be responsible for their own healthcare insurance.

A major concern which has impacted Medicaid government spending negatively is the varying eligibility requirements that exist between states. At the inception of the Medicaid program, the Kerr-Mills Act held all states independently accountable for developing eligibility standards and benefit coverage.⁸ While the federal government did provide some guidelines, states were only required to provide “some institutional and some noninstitutional services” that “include reasonable standards”.⁸ Vague and undefined statements like this resulted in low numbers of eligible beneficiaries. Due to the Kerr-Mills Act, states Medicaid programs were drastically different depending on the states development of the program.⁸ Some states chose not to have any Medicaid program at all.⁸ With the Kerr-Mills Act in place only five states were known to provide comprehensive services to those eligible.⁸ Due to the inconsistency and inability to provide assistance to those for whom the program originally intended, changes were made.⁷ The federal government changed the eligibility guidelines mandating that certain groups of people must be covered under the Medicaid program.⁸ In addition, the income levels were determined and set to ensure states did not lower them, and benefits were widened to ensure that comprehensive services were provided.⁸ These changes in eligibility created a standard benefit that pertained to all eligible recipients.⁸

Affordable Care Act (ACA)

Most recently, the ACA was passed in an attempt to lead the nation toward a universal health insurance system.⁷ It was designed to refocus the Medicaid system and expand Medicaid eligibility extensively, while delegating how the program should be administered.⁸ Due to the changes in legislation, and the creation of the ACA, Medicaid has become the largest federal health insurer.⁹ For this model to succeed, the federalist relationship must shift from state controlled to a federally controlled model.⁷ This type of regulated healthcare would decrease the autonomy of individual states, while increasing federal government financial dependency.⁷ Additionally, the ACA, requires that the federal government pay 100% of the costs for “newly eligible” enrollees

⁶ Anderson, Eva. State Budget Crises, National Health Reform. 2011. Westlaw. 30-MAY Am. Bankr. Inst. J. 14.

⁷ Blum, Alexander B., Rosenbaum, Sara, Giordano, Amanda, Park, M. Jane, & Brindis, Claire D. Article: Implementing Health Reform in an Era of Semi-Cooperative Federalism: Lessons from the Age 26 Expansion. 2015. 10 J. Health & Biomed. L. 327.

⁸ Hermer, Laura D. Federal/State Tensions In Fulfilling Medicaid’s Purpose. 2012. 21 Annals Health L. 615.

⁹ Tewarson, Hemi D. J. Medicaid Issues. AHLA Seminar Materials. 2006. AHLA-PAPERS P11080614.

from January 2014 through December 31, 2016, slightly decreasing support to 90% after 2019.⁵ Allowing the federal government to foot this bill creates a burden to taxpayers, specifically those who have responsibly provided themselves with healthcare insurance. The institution of the ACA has provoked mixed emotions across the nation. By August of 2014, twenty-two states had chosen not to participate with the Medicaid expansion required to make the ACA effective.⁷ As of January of 2018, eighteen states have continued to reject the Medicaid expansion implemented under the ACA.¹⁰ Protected by the Tenth Amendment, states cannot be forced to participate in the ACA.⁷ States that rejected the legislation viewed it as “unconstitutional coercion upon the states” and refused to adopt the new healthcare legislation.⁷ Despite this rejection, states did find value in pieces of the ACA which simply increased insurance coverage for young adults who would otherwise not be covered.⁷ Those young adults, under the ACA, were permitted to continue their coverage through their parent’s health care benefit until age 26.⁷ By instituting this law, instantly, 2.5 million young adults gained insurance coverage between 2009 and 2011.⁷ Increasing the age that allows parents to continue to provide medical coverage to adult children, from their benefit packages, has assisted young Americans and decreased government spending.

Enrollment & Eligibility

As the Medicaid program has evolved, many amendments have been made that have affected the eligibility requirements. For example, states have been afforded the capability to qualify an individual for services if their medical expenses exceed their income.¹¹ This is referred to as spending down. This shows how the government has worked to ensure that children and disabled Americans are provided the coverage they need.¹¹ Adversely, some states have fine-tuned their eligibility criteria which has greatly impacted the federal matching system and driven up government Medicaid spending. As Medicaid eligibility criteria developed, complicated categories were defined to classify what individuals could be covered under.⁹ The categories included: Mandatory Categorically Needy, Optional Categorically Needy, and Optional Medically Needy.⁹ Individuals were covered under the Mandatory category if they had the lowest income children, were pregnant or postpartum, or if the person had a disability or were elderly.⁹ State Medicaid coverage was optional when considering eligibility of needy individuals depending on income levels, and other supports provided.⁹ Within the federal eligibility guidelines, it is also stated that “immigrants who fail to qualify for Medicaid solely” because of “their immigration status must receive coverage of emergency medical services (excluding organ transplants).⁹”

Medicaid & Immigration

Currently, federal requirements mandate that Medicaid services, as stated on their webpage’s, cannot be rendered to undocumented immigrants except in emergency situations.¹² However, what exactly is meant by emergency services is vaguely defined when comparing states eligibility requirements. For example, some states eligibility statements are written stating that,

¹⁰ Henry J. Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. January 16, 2018. <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹¹ Perkins, Jane. Medicaid: Past Successes and Future Challenges. 2002. 12 Health Matrix 7.

¹² Centers for Medicaid and Medicare Services. Eligibility for Non-Citizens in Medicaid and CHIP. 2018. <https://www.medicaid.gov/medicaid/outreach-and-enrollment/downloads/overview-of-eligibility-for-non-citizens-in-medicaid-and-chip.pdf>.

“Medicaid is a federal and state funded program that serves needy individuals and families who meet financial and other eligibility requirements and certain other individuals who lack adequate resources to pay for medical care.”¹³ The way in which it is stated, provides states with the ability to manipulate how coverage is provided and to whom. In comparing states eligibility criteria, at least twenty-nine states currently offer Medicaid emergency services, per their websites, to undocumented illegal immigrants.¹³ Twelve of the twenty-nine, include the vague eligibility statement describe previously stating that coverage is provided for “other certain individuals” who are eligible.¹³ In addition, three states do not require any type of citizenship documentation to be provided in order to be eligible for Medicaid benefits.¹³ Twenty-two states do not mention coverage for undocumented immigrants at all, even in regard to emergency services.¹³ The vast differences of state’s Medicaid policies has resulted in some state’s relying on extensive federal funding for support, while promoting financial dependency in the immigrant population.

It is impossible to know how many undocumented immigrants live within the United States.¹⁴ The Department of Homeland Security estimates that 12.1 million illegal immigrants were residing in the United States as of January of 2014.¹⁵ Today, the Federation for American Immigration Reform (FAIR) estimates that 12.5 million unauthorized immigrants are living in the United States.¹⁶ While some illegal immigrants do pay taxes, assisting in creating federal and state revenue, the amount of money generated is estimated to be extremely modest when considering the funds that are spent to support this population of people.¹⁴ It is believed that illegal immigrants do not contribute as much because they are more likely to be unemployed or work in jobs that earn low wages.¹⁴ Specifically, FAIR reports illegal immigrants tax contributions to be federally \$15,447,897,700, and state to be \$3,520,960,000 for a total payment of \$18,968,857,700 dollars.¹⁶ In addition, undocumented immigrants are less likely to have health care insurance of any kind.¹⁴ In 2000, it was reported that counties that border the U.S. and Mexico spent approximately \$190 million in health care costs to support illegal immigrants.¹⁴ In 2013, the federal government spent \$45,870,474,332 dollars supporting unauthorized immigrants.¹⁶ States and local costs were reported at \$88,992,981,032 dollars for a national total of \$134,863,455,364 dollars in aid to support this population of people.¹⁶ The difference in the amounts paid into the U.S. tax system minus the amount that was paid out to support unauthorized immigrants is a stunning \$115,894,597,664 dollars.¹⁶ The tax burden placed on United States citizens to finance undocumented immigrants is unsustainable for our government budget and economy.¹⁶ Immigration reform must be enacted and enforced in order to decrease Medicaid spending and is absolutely necessary, to better control government spending.

¹³ Eligibility For Medicaid. 2018. <http://www.medicaidoffice.net/medicaid-eligibility>.

¹⁴ Merrell, Melissa. December, 2007. The Impact of Unauthorized Immigrants on the Budgets of State and Local Governments. <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8711/12-6-immigration.pdf>.

¹⁵ Baker, Bryan. January, 2014. Estimates of the Unauthorized Immigrant Population Residing in the United States. https://www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20Population%20Estimates%20in%20the%20US%20January%202014_1.pdf.

¹⁶ FAIR, Federation of American Immigration Reform. 2018. <http://www.fairus.org/issue/publications-resources/fiscal-burden-illegal-immigration-united-states-taxpayers>.

Federal & State Spending/Deficits

Throughout American history, the growth rate of government healthcare spending has surpassed the economy's growth, by at least 2% each year.¹⁷ This growth in federal spending has resulted in the Medicaid budget becoming a significant part of the gross domestic product. The gross domestic product, or DNP, is "the total value of goods produced, and services provided in a country during one year."¹⁸ Due to the strong correlation between government spending and Medicaid growth, federal deficit reduction debates have long focused on decreasing Medicaid spending. With the development of the ACA and Medicaid expansion, causing enrollment to continue to rise, Medicaid costs will undoubtedly continue to rise as well.¹⁷ It is anticipated that Medicaid expenditures will increase about 8.5% every year.¹⁷ It is also expected, that the implementation of the ACA will increase the federal deficit by at least \$340 billion dollars over a ten year period.²⁵ Unfortunately, the government's income is far exceeded by the debt that it owes, making this system unsustainable.

Today, the Medicaid system has become the "third largest social program in the federal budget and one of the largest components of state budgets."¹⁹ State budgets have become so indistinguishably connected to federal funding that withdrawal from the Medicaid program has become politically and financially impossible.²⁶ Most recently, evidence suggests that Medicaid enrollment is the greatest factor that influences the amount of government spending.¹⁷ Therefore, to gain control of government deficits and spending, efforts should be focused on substantially decreasing Medicaid enrollment.

Within the United States, there are approximately 5,100 hospitals.¹⁹ Of those hospitals 200 are owned solely by the federal government to care for the military or veterans. An additional 1,000 hospitals are owned by state and local governments.¹⁹ State and local government owned healthcare facilities receive payments in the following ways: Medicaid or Medicare reimbursements, local tax revenues, private insurance payments, donations or grants.¹⁹ Hospitals owned federally, are funded entirely with federal tax revenues.¹⁹ Federally owned hospitals are another major contributor to healthcare spending.²¹ An example of an exclusively federally funded institution is the Veteran Administration Hospitals.²¹ In the upcoming proposed FY 2019 budget, \$76.5 billion has been proposed to support Veterans.²⁰ In 2016, the federal government spent \$63,473,220 to cover healthcare costs of veterans.²¹ Considering the debt that these individuals have paid to our Country, the least we can do is ensure that their healthcare needs are met and maintain their safety as they grow old.

New York State

Among the fifty United States, New York State, is rated number two of all states, spending the second largest amount on healthcare.²² In 2014, New York State spent \$192,809,000 in

¹⁷ Holahan, John., McMorrow, Stacey. Medicare and Medicaid Spending Trends and the Deficit. 2012.

<https://www.nejm.org/doi/full/10.1056/NEJMp1204899>.

¹⁸ Google Dictionary. 2018. Definition of Gross Domestic Product. <https://www.Google.com>.

¹⁹ Hoffman, Joan. January 9, 2018. Experience in Healthcare Management. <https://www.quora.com/How-are-hospitals-in-the-USA-funded-private-or-government>.

²⁰ Annual Budget Submission FY 2019. 2018. <https://www.va.gov/budget/products.asp>.

²¹ National Centers for Veterans Analysis and Statistics. 2018. <https://va.gov/vetdata/Expenditures.asp>.

²² Kaiser Family Foundation (KFF). 2018. Health Care Expenditures by State of Residence (in millions). <https://www.kff.org/other/state-indicator/health-care-expenditures-by-state-of-residence-in->

healthcare expenditures.²² New York comes in second place, right behind California, who obtained the number one spending title with \$291,989 million.²² It is believed, that a notable contributing factor to the astronomical state spending numbers in New York, is how reimbursements are focused.²³ “New York continues to spend about double the national average per patient, due to higher reimbursements for services such as hospital care, nursing homes, and mental health facilities.”²³ While the economy’s resources are drained, little thought is given to decreasing high cost care by realistically assessing the benefit of treatment vs marginal life prolongation.²³ Switching the focus of healthcare reimbursement to provide higher reimbursement rates for preventative care and decrease reimbursement related to terminal patient’s life sustenance should reduce spending.²³ New York’s Medicaid program should increase reimbursement for services such as long-term care, non-acute treatment (smoking cessation, nutrition, specialized rehabilitation), and mental health.²⁴ These changes could promote healthier individuals who require less healthcare services overall.²⁵ Currently, “New York covers nearly two million people under the medically needy category, far more than any other state; making medical necessity the most common grounds by which people qualify for New York Medicaid.”²³ “Medicaid law requires a physician treating a Medicaid patient to provide all necessary medical services for the patient.”²³ By doing so, the system encourages providers to treat patients, with no limitations, which results in increased costs of the services provided, which are then billed to the government.²³ In addition, the Medicaid population “tends to be an irresponsible and undisciplined group as compared to the population at large.”²³ Often physicians report that Medicaid patients “are highly unreliable; they walk in without appointments and regularly miss appointments that they do schedule.”²³ Unique to New York State, as of 2016, approximately one-third of New York’s population relies on Medicaid for healthcare.²⁴ “Unless these patients are given a clear financial stake in becoming and remaining as healthy as possible, Medicaid will continue to become increasingly inefficient.”²³ It is crucial for our Country’s economic sustainability that individuals become responsible and accountable for their own healthcare. Depending on the government to finance poor life choices, and then continuing to condone those choices, is no longer acceptable.

Health Care Compliance

While working to increase support for the ACA, one key point that the Obama Administration pushed, was a promise to ensure fraud enforcement and detection would be easier to identify under the new legislation.²⁵ Once the ACA was passed, Congress and other enforcement agencies’ realized that the old methods of detection, prosecution, and enforcement were not preventing federal fraud from occurring within the Medicaid program.²⁵ “The sheer size of federal healthcare programs incentivizes crooks to ply their fraudulent schemes, knowing it is very unlikely they will ever be caught.”²⁵ In making the law more stringent with the ACA, provider enrollment in the programs became more difficult, and committing a fraud was made easier.²⁵ These changes assisted the Department of Health and Human Services (HHS), Office of Inspector General (OIG), and Department of Justice (DOJ) to penalize those who committed healthcare fraud

[millions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Health%20Spending%22,%22sort%22:%22desc%22%7D.](#)

²³ Fastiggi, Joseph. New York Medicaid: Never Can Say Goodbye. 2007. 16 Cornell J.L. & Pub. Pol’y 581.

²⁴ Norris, Louise. New York and the ACA’s Medicaid Expansion. 2016. <https://www.healthinsurance.org/new-york-medicaid/>.

²⁵ Hammond, Jeffrey B. What exactly is Healthcare Fraud After The Affordable Care Act? Fall, 2012. 42 Stetson L. Rev. 35, *35.

and identify civil violations.²⁵ The other compliance driven selling point of the ACA was the claim that by tightening the healthcare laws, the revenue recovered would pay for the program.²⁵ In the end, those claims “were nothing more than rhetorical ruffles and flourishes meant to whip the President’s political base into fevered anticipation of passing the bills now known as the Affordable Care Act.”²⁵ Although strengthening fraud detection and elimination are important factors to be determined, the revenue recovered from it could never come close to paying for the programs, initiative, and mandates of the ACA.²⁵ “In 2011, the federal government had its best year ever in fraud detection and recovery, posting \$4.1 billion in total judgments and settlements of fraud-related cases.²⁵ While substantial, the numbers show clearly that this type of reform will never account for costs that the ACA produces.²⁵

In order to prevent non-compliance from becoming the normal practice, the Centers for Medicare and Medicaid Services (CMS), provides federal oversight within the Department of Health and Human Services (HHS).²⁶ However, compliance is also examined and programs are implemented by individual agencies within each state.²⁶ Agreeing to participate in the Medicaid program obligates states, providers, and healthcare facilities to follow all requirements outlined by the federal Medicaid statutes.²⁶ Federal statute 42 U.S.C. § 1396c, holds states accountable to Medicaid requirements and allows the Secretary of Health and Human Services to investigate and/or prosecute under the statute.²⁶ If a state, provider, or healthcare facility is found to have a finding of noncompliance, some or all of the federal government grant payments will be withheld until that entity has proven they are “acting in accordance” with the requirements within the law.²⁶ On a federal level, compliance should be enforced using legislation.²⁶ While that is the goal, allowing individuals to file actions, under the statutes, would assist in holding the states accountable in terms of compliance.²⁶

Unfortunately, our current system is not well equipped to ensure individual compliance within states for several reasons.²⁶ One reason this happens is that the main role of federal grant agencies is to encourage healthy relationships and ensure cooperation with the states, this results in less enforcement of the law.²⁶ Another reason noncompliance issues are not well enforced is the required change may substantially devastate the program that is supplying aid to the people, and therefore is rarely invoked.²⁶ A third reason that noncompliance is not effectively dealt with is that in order to cut off aid to a state, CMS is required to hold a hearing to determine noncompliance.²⁶ While by law, this process is required, it is generally a demanding and lengthy process and therefore not as likely to be pursued.²⁶ Lastly, “federal administrators are not accountable to local beneficiaries.”²⁶ This can cause “good working relations” to result in biased judgments resulting in disregarding their state counterparts and the needs of individual Medicaid recipients.²⁶ As a result, federal courts have made it more difficult for individuals to take legal action, and instead focus on forcing states to respect the federal Medicaid requirements.²⁶ Ultimately, states compliance procedures vary and there is a lack of “institutional precedent” that would ensure fair hearings.²⁶ All these gaps in the compliance procedures have brought about lost revenue and contributed to government spending.

Another way in which government Medicaid spending has grown exponentially is due to the abuse of federal programs that states have taken advantage of. Disproportionate share hospital programs were developed and instituted by legislation, to benefit hospitals who provide care to large amounts of Medicaid recipients and low-income individuals that are uninsured or have

²⁶ Donenberg, Jon. Medicaid and Beneficiary Enforcement: Maintaining State Compliance With Federal Availability Requirements. 2008. 117 Yale L.J. 1498.

special needs.³ This program was created in attempt to provide financial assistance to hospitals who would otherwise not be reimbursed for services rendered.³ Initially, the program worked as it was intended, paying out \$569 million federally in 1989.³ However, states began to manipulate the system by using donations and provider tax revenues to increase federal Medicaid funding, while avoiding producing their share of the matching funds.³ Prior to 1985, Medicaid guidelines denied states the right to use donated funds.³ This was not permitted because of the possibility for the funds to be abused and violate anti-kickback laws.³ Eventually, the guidelines were changed to permit use of donated funds for any purpose.³ In many cases, states were embezzling federal funds that were meant for disproportionate share hospitals.³ The abuse continued increasing the federal Medicaid spending to \$16.5 billion by 1992.³ That increase resulted in a 4,000 percent increase in spending in just four years and was concentrated in about fifteen states.³ One example of gross non-compliance and abuse of disproportionate share programs occurred in Pennsylvania.³ One-hundred seventy Pennsylvania hospitals pooled their funds, through a foundation they developed, and borrowed \$365 million from a lending institution.³ The funds they borrowed were then donated to the state treasury.³ Due to the disproportionate share agreement with Pennsylvania, they received \$380 million as a match to their \$365 million.³ The \$365 million borrowed was distributed between the 170 hospitals making up the money they were loaned.³ The \$380 million they were matched was distributed to 260 hospitals in the state.³ Ultimately, legislation was passed placing stricter criteria on disproportionate share payments to prevent this type of fraud from occurring in the future.³ This is just one instance in which noncompliance has caused Medicaid spending to soar over the years, leaving our country in financial crisis.

In the 1970s, President Nixon introduced block grants to the Medicaid system.²⁷ Block grants capped the amount that the federal government could spend in Medicaid spending.²⁸ This gave states the ability to determine how to spend it within their Medicaid program.²⁸ While block grants would decrease government spending, largely over time, several problems were identified with block grants.²⁷ Block grants are often criticized because they are not designed to increase funding, based on growing health care costs.²⁷ Depending on the level of federal support that states relied on to fund their Medicaid programs, determined the type of impact that each state experienced when block grants were instituted.¹⁶ Each state's budget was effected but the impact varied greatly.²⁷ Implementation of block grants would force states to replace lenient eligibility criteria, and replace it with stricter criteria.²⁷ This would force states to redefine who truly needs services, instead of providing lifetime assistance without limits. Similar to block grants, another suggested reform is "per capita cap".²⁷ This option would provide assistance to states based on a limited fixed dollar amount.²⁷ The amount provided to states is calculated by "multiplying a per capita allowance times the number of eligible program beneficiaries.²⁷ The "per capita cap" would be beneficial in assisting our nation to decrease government Medicaid spending, while placing accountability and responsibility on individuals to support themselves. However, it does not address the huge enrollment numbers which has left gaps and resulted in states using non-compliant methods to meet budget needs.

Under the Bush administrations, states were granted considerable flexibility to modify their Medicaid programs.⁸ This flexibility came through Section 1115 which allowed the Secretary of

²⁷ National Council on Disability. 2018. <https://www.ncd.gov/policy/chapter-2-origins-and-effects-federal-block-grant-programs>.

²⁸ Luthra, Shefali. January 24, 2017. Kaiser Health News. Everything You Need to Know About Block Grants – The Heart of the GOP's Medicaid Plans. <https://khn.org/news/block-grants-medicaid-faq/>.

Health and Human Services the authority to waive Medicaid statutory provisions.⁸ If a waiver was requested by a state and granted, that state would be exempt from being viewed as noncompliant, thus allowing them to maintain eligibility for matching of federal funds while having the benefit of the waiver granted.⁸ The Bush administration has been criticized for granting waivers which did not completely align with the Section 1115 requirements.⁷ The waiver system was designed to expand Medicaid eligibility to people who were earning up to 200 percent of the federal poverty level.⁸ Unfortunately, these waivers often resulted in the funds being used in ways that were not originally intended.⁸ The misuse of the federal funds has contributed to states' financial dependency on the Medicaid system that continues today. Instead, Medicaid core values should be upheld strictly focusing on providing assistance to those who meet eligibility requirements and need it most.⁸ Allowing states to place excessive limits on eligibility and coverage should only be permitted if the costs are funded by that state, not the federal government.⁸

Medicaid Reform

Medicaid reform is essential to decrease government spending, ensure compliance within the Medicaid program, move Americans toward personal responsibility and independence while decreasing dependency on government assistance. Based on research, decreasing enrollment and clearly outlining eligibility requirements, refocusing reimbursement, requiring individuals to be personally responsible, improving compliance methods and standardizing pricing for healthcare services will greatly decrease government spending and dependency. Without Medicaid reform spending will remain unsustainable, and will result in increased government dependency.²⁹ The ACA has increased financial strain on the government and leaves the taxpayers to finance it.²⁹

Decreasing enrollment in Medicaid is one way to drastically decrease government spending. To remarkably decrease enrollment would require the ACA to be repealed and replaced.²⁹ Due to the Medicaid expansion, through the ACA, enrollment in the Medicaid program is projected to increase approximately to 95 million by 2022.²⁹ Significant growth like this will indisputably intensify many existing problems of the Medicaid program.³⁰ "This enormous influx of covered lives will place pressure on a number of weak spots in the HHS oversight of the Medicaid program."³⁰ For example, although the number of Medicaid recipients has grown exponentially, the number of physicians attempting to provide them care, remains unchanged.³⁰ This may cause providers to quit participating with the Medicaid program completely rather than be burdened with the disproportionate ratio of providers and patients, only escalating problems.³⁰ Enrollment pressure will result in increased tensions between providers and states, and states and the federal government.³⁰ Another way to decrease enrollment is by ensuring that federal eligibility laws are enforced and clarified. States Medicaid eligibility requirements, in terms of undocumented immigrants, is written vaguely and coverage is largely determined by individual states which greatly impacts government spending.¹³ Enforcing the federal requirements set for undocumented immigrants would decrease government spending by approximately \$116 billion dollars.¹⁶ The Heritage Foundation proposes decreasing enrollment by transitioning non-disabled individuals out of Medicaid and into private insurance.²⁹

Transitioning non-disabled individuals to private insurance would also require refocusing of the Medicaid reimbursement goals. Historically, reimbursement models provide very little

²⁹ Schaefer, Nina Owcharenko. Medicaid Reform: More than a Block Grant Is Needed. The Heritage Foundation. May 4, 2012. <https://www.heritage.org/health-care-reform/report/medicaid-reform-more-block-grant-needed>.

³⁰ Huberfield, Nicole. Where There Is A Right, There Must Be A Remedy (Even In Medicaid). 2014. 102Ky. LJ. 327.

reimbursement for preventative care from primary care physicians, and instead provides large reimbursement for more acute and costly care.³¹ Based on the state, primary care reimbursement rates varied greatly with some states only reimbursing 0.33 of the costs, and an U.S. average of 0.66 reimbursement rate.³² If reimbursement was increased for primary care, improving preventative care in the population, the overall health of individuals would improve. This would decrease government spending and help prevent situations in which preventative care was not attainable, resulting in leaving patient's conditions untreated, until more costly treatment is required or death results.²³ Increasing the reimbursement rates can produce long term cost savings while increasing the number of providers who choose to participate with Medicaid.³¹ In addition, a multitude of studies show that Medicaid enrollees are "much less likely than Americans with private health insurance to have a relationship with a primary care doctor or to receive needed preventative care, and much more likely to receive their care in hospital emergency room settings or public clinics."³³ This is mainly due to the lack of provider participation in the Medicaid program directly related to low reimbursement rates.³³ The lack of federal regulatory guidance related to rate setting in terms of compliance has also contributed to states "using their discretion" to work around federal law to make ends meet.³³ Conversely, reimbursement cuts are not often discussed in terms of decreasing spending, where the only benefit to the patient is prolonging life.²³ Reducing spending on terminally ill patients or patients for whom treatment will not affect their outcomes, would decrease government spending.²³ Refocusing the reimbursement would encourage Medicaid recipients to engage in preventative care, improve overall individual health and personal responsibility; while decreasing government spending.²³

While many Americans have claimed that personal habits or risky behaviors are private, they impact health care socially and financially.³⁴ Poor lifestyle decisions such as being sedentary, using tobacco, and poor nutrition has resulted in decreased quality of life, premature death and/or disability, and rising health care costs.³⁵ Approximately 87% of individual health care costs are related to individual's lifestyle choices.³⁵ Unfortunately, despite employers and government attempts to change unhealthy behaviors, Americans have resisted making lifestyle changes.³⁴ U.S. health care systems allows individuals to devour health care services with little consideration to the costs incurred; this contributes to higher costs for everyone in the health care system.³⁵ Employers have begun instituting stricter measures to ensure workers change behaviors.³⁴ Most state governments have restricted smoking on the state properties to discourage unhealthy habits.³⁴ When individuals are engaged and participate in health care decisions, they are less likely to be hospitalized or require emergency room treatment that can be costly.³⁵ "Accountability for personal lifestyle choices is becoming an important component of the struggle to control costs and improve health."³⁴

³¹ Perkin, Jane. Increasing Provider Participation In The Medicaid Program: Is There A Doctor In The House? 1989. 26 Soc.Sec.Rep.Serv. 846.

³² KFF. Medicaid to Medicare Fee Index. 2016.
<https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³³ Clark, Brietta R. Medicaid Access, Rate Setting And Payment Suits: How The Obama Administration Is Undermining Its Own Health Reform Goals. 2012. Howard Law Journal. 55 How. L.J. 771.

³⁴ Clark, Steve. Personal Accountability Part Of Health Care Cost Equation. January 2008; Vol 4, Num 8.
<https://www.lhsfna.org/index.cfm/lifelines/january-2008/personal-accountability-part-of-health-care-cost-equation/>.

³⁵ Cordani, David. Individual Engagement and Accountability In Health Care. 2018.
<https://www.cigna.com/assets/docs/about-cigna/sustainability/aspens-institute-paper-cigna-10714.pdf>.

The American Medical Association (AMA) has endorsed requiring individuals to obtain and maintain health insurance as a personal responsibility.³⁶ The AMA holds that individuals or families who earn 500% or more than the federal poverty level (FPL) must have health insurance or face tax penalties.³⁶ Enforcing this personal responsibility requirement would result in five million Americans, 10% of the population, gaining health insurance.³⁶ “Individuals have a responsibility to obtain health insurance when possible because of the social burden posed by those who fail to obtain coverage.”³⁶ In Massachusetts, legislation was enacted in 2006 which requires individuals at 300% of above the FPL to purchase health insurance or face tax penalties.³⁶ These mandates decreased taxpayer’s responsibility and government spending. The ACA includes legislation that requires individuals to maintain a level of personal responsibility, by requiring Americans participate in the individual shared responsibility provision.³⁷ The individual shared provision mandates that minimum essential coverage must be maintained or qualify for an exemption.³⁷ Failure to meet this mandate results in making a shared responsibility payment when individuals file their federal income tax return.³⁷ While ensuring Americans have health insurance does promote healthier Americans, the large enrollment numbers that result from the ACA, works oppositely increasing tax payer’s financial responsibility and government spending drastically.

The Department of Health and Human Services (HHS) and the Centers For Medicare & Medicaid Services (CMS) are also taking a closer look at defining personal responsibility within the Medicaid program. On January 11, 2018, HHS & CMS announced a new policy which “incentivizing work and community engagement among non-elderly, non-pregnant, adult Medicaid beneficiaries” authorized under Section 1115 of the Social Security Act.³⁸ Studies show compelling evidence that unemployment is “harmful to health, including higher mortality; poorer general health; poorer mental health; and higher medical consultation and hospital admission rates.”³⁸ While this policy is a shift from previous policies it is “anchored in historic CMS principles that emphasize work to promote health and well-being.”³⁸ The policy was written so that states can adopt the policy in ways that best meet the needs of their beneficiaries and exemptions may be given when appropriate.³⁸ This policy was developed to assist individuals and families in attaining independence and rising out of poverty, aligning with Medicaid program objectives.³⁸ However, U.S. District Judge James E. Boasberg halted the Medicaid work requirements due to his concern that the requirement to work will leave significant potential coverage losses.³⁹ It is estimated that 95,000 people could lose coverage due to work requirements. However, a 2013 Gallup poll discovered that working Americans are two times less likely to experience depression when working full-time.³⁸ In addition, community engagement has been linked to improved health outcomes, and can also lead to paid employment which may result in individual’s ability to obtain private health insurance.³⁸

To transition individuals into private health insurance plans, that they can afford, private health insurance companies must accept some responsibility as well. Individual responsibility for

³⁶ American Medical Association. Individual responsibility: Requiring those who can afford it to have health insurance. 2008. <https://academic.udayton.edu/lawrenceulrich/315Articles/AMAindivresponsibility.pdf.s>

³⁷ IRS. Individual Shared Responsibility Provision. 2018. <https://www.irs.gov/affordavle-care-act/individuals-and-families/individual-shared-responsibility-provision>.

³⁸ Center For Medicare & Medicaid Services. Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. January 11, 2018.

³⁹ Times Union. Judge’s ruling slows plans for Medicaid work requirement. July 2018. <https://www.timesunion.com/news/medical/article/Judge-s-ruling-slows-plans-for-Medicaid-work-13049120.php>.

health insurance increases the likelihood that insurance market reform will occur.⁴⁰ Private health insurers should be required to allocate a portion of their profits toward assisting low-income Americans with obtaining health insurance, while benefiting from a government awarded tax deduction. UnitedHealth Group's 2017 financial report outlines the company's broad growth with a 9% increase in revenue totaling \$201 billion dollars, a 25% increase in adjusted net earnings, and 39% increase in cash flow from operations.⁴¹ Excellus, another major health insurance provider, has reported profit margins of \$99.5 million in Syracuse, New York alone.⁴² This shows a 1.7% profit margin increase for Excellus.⁴² Legislation should be developed to hold all parties responsible, assist Americans in obtaining private health insurance, while decreasing government spending.

Ensuring that compliance standards are held and enforced will support good faith practices, with a goal of decreasing government spending. Administrative hearings may be the best way to compel states to follow federal requirements and maintain compliance accountability.²⁶ Federal courts have greatly reduced the scope in which individuals can bring actions that force states to obey federal Medicaid requirements.²⁶ However, "most jurisdictions allow fair hearing challenges to regulatory or legislative attempts by states to restructure their Medicaid programs."²⁶ Unfortunately, state fair hearings do not bare the weight felt in federal actions and is not an adequate substitute.²⁶ These hearings do pose a threat and may serve as a deterrent to states to conform to compliance standards.²⁶ "The best option for the federal government to ensure compliance with federal Medicaid requirements might be a legislative fix."²⁶ Despite the promises that the ACA would fundamentally revolutionize healthcare fraud law, that has not happened.²⁵ Since the implementation of the ACA, the focus of compliance has shifted from fraud found in federal programs to looking closer at fee-for-service reimbursements resulting in fraudulent behavior.²⁵ Regardless, Congress does support non-compliance in any form, and "is showing the seriousness with which it combats fraud and the massive drain that it wreaks on the federal" government by focusing on enforcement to ensure compliance.²⁵

Arguably, the most impactful means of reducing government spending on health care services comes through price transparency and standardization of health care services.⁴³ Healthcare services are currently provided without offering any information to the consumer about the actual costs of services.⁴⁴ Patients are expected to enter into contracts which require that they pay for the services provided but are not told what the cost will be for the service.⁴⁵ In 2008, the Congressional Research Service (CRS) found that increasing the transparency of pricing would improve competition and drive down healthcare prices.⁴³ Developing price transparency in federal healthcare programs creates a culture of accountability for the costs of healthcare services.⁴⁴ Informing consumers on pricing would allow individuals to shop for the best prices, while

⁴⁰ Wilson, Cecil. B. AMA: Individual responsibility for health insurance helps America's patients, pocketbooks. May 12, 2011. <https://www.kevinmd.com/blog/2011/05/ama-individual-responsibility-health-insurance-helps-americas-patients-pocketbooks.html>.

⁴¹ UnitedHealth Group. UnitedHealth Group Reports 2017 Results. 2018.

<https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2018/UNH-Q1-2018-Release.pdf>.

⁴²Feltner, Kerry. Excellus reports 2016 net income of 1.7 percent. March 1, 2017.

<https://rbi.net/2017/03/01/excellus-reports-2016-net-income-of-1-7-percent/>.

⁴³ Muir, Morgan A., Alessi, Stephanie A., & King, Jaime S. Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending? 2013. 4 Wm. & Mary Pol'y Rev. 319.

⁴⁴ Claiborne, Anne B., Hesse, Julia R., & Roble, Daniel, T. Legal Impediments To Implementing Value-Based Purchasing In Healthcare. 2009. 35 Am. J.L. & Med. 442.

comparing quality data of different providers and moving away from fee-for-service models.⁴³ While making the pricing transparent is an initial step to decrease spending, price standardization of health care services are more likely to decrease government spending immediately. In 2014, the federal government released the charges they received for healthcare services, the exact same services, however, the variation in pricing was astounding between healthcare facilities.⁴⁵ A joint replacement in Ada, Oklahoma cost \$5300, but in Monterey Park, California cost \$223,000.⁴⁵ The same report showed that treating a blood clot in New York City, New York could cost consumers between \$29,869 and \$51,580.⁴⁵ In Bethesda, Maryland treatment of simple pneumonia cost consumers on average \$5,284, while in Philadelphia, Pennsylvania the same treatment cost \$79,365.⁴⁵ To control healthcare costs and reduce government spending price standardization is crucial. Price standardization has already been implemented in Maryland.⁴⁶ Maryland functions as an “all-payer system” where everyone pays the same rates for the same treatments.^{46,45} This model promotes payment based on the quality rather than quantity.⁴⁶ Maryland has incentivized preventative care and reduced hospital admissions by setting pricing.⁴⁶ As a result, the “all-payer system” “has successfully controlled the hospital care cost spiral.”⁴⁵ Getting control of costs by standardizing pricing of healthcare services will immensely decrease government spending, make compliance more easily managed, and refocus reimbursement. “With the implementation of the ACA, the incentive structure doesn’t change,” instead it removes incentive for insurance companies to care at all.⁴⁵ Historically, patients have given insurance companies complete control over pricing.⁴⁵ Because insurance providers are minimally invested in controlling pricing, the consumer ends up footing the bill.⁴⁵ For example, if an insurance company’s payout effects its profit margins, the company simple increases premiums for the following year to make up the costs.⁴⁵ These methods have only driven health care costs out of control. Pricing standardization offers a way to even out access to healthcare, without using government funds to finance healthcare for all individuals who became eligible under the ACA.⁴⁵

Conclusions

Since the inception of Medicaid in 1965, government spending has soared to unimaginable heights. Continuing to spend half a trillion dollars annually is simply not sustainable as a nation. Despite attempts to create real Medicaid reform, reform efforts have fallen short of addressing the problems, ensuring compliance of programs, and have resulted in increased dependency of the people for government funded support. The ACA and Medicaid enrollment expansion, lenient eligibility practices, faulty compliance combined with state compliance abuse, and unbalanced budgets by the states as well as federally, have created an enormous government spending deficit. Effective Medicaid reform must be enacted now to control government spending, ensure compliance measures are met, and assist Americans in gaining financial independence, while decreasing government dependency and avoiding further economic drain. By decreasing Medicaid enrollment, clarifying and enforcing eligibility laws, refocusing provider reimbursement, holding all parties involved personally responsible and accountable, continuing to enforce compliance measures and enacting new legislation, and standardize healthcare pricing; government spending and dependency can be significantly decreased while transitioning Americans to financial

⁴⁵ McLean, John T., & Datar, Vinay. Mastering The Chargemaster: Minimizing Price Gouging And Exposing The Structural Flaws In The

⁴⁶ Gebelhoff, Robert. The health-care reform we’re ignoring? Standardizing the price of care. June 5, 2017. https://www.washingtonpost.com/news/in-theory/wp/2017/06/05/the-health-care-reform-were-ignoring-standardizing-the-price-of-care/?noredirect=on&utm_term=.c3c2bee1c8d7.

independence. While these solutions are many, they are all essential steps in Medicaid reform. These reform options combined can successfully meet Americans needs, without depending on the government (aka taxpayers) to make it possible.