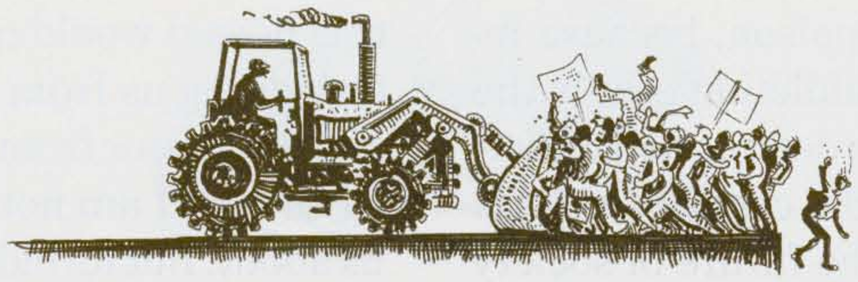

Medicaid Freedom of Choice

by Stephen Moore and Peter Ferrara

PERHAPS THE MOST ARRESTING WAY to illustrate the breakdown of Medicaid is to explain how a 12-year-old Maryland boy died of a toothache.

Medicaid, the national entitlement program for the poor, is supposed to ensure that no one suffers without essential health care for lack of money. But because the program pays doctors and hospitals only about 60 percent of what they normally charge, Medicaid patients face grave difficulties obtaining timely and essential care, and suffer worse health outcomes as a result.

Occasionally, the ensuing tragedies play out in newspapers, as with this 2007 report from the *Washington Post*: A 12-year-old Maryland boy named Deamonte Driver complained of a headache, which ultimately stemmed from an abscessed tooth. His mother had not noticed the problem, partially because she was working frantically to find a Maryland dentist to treat her other son, who had six rotten teeth. But of the approximately 5,500 dentists in the entire state, only about 900 accepted Medicaid. None of the children received routine dental care. By the time Deamonte complained, the infection in his tooth had spread to his brain. He was rushed to Children's Hospital for emergency surgery and spent more than two weeks there. Then one night, he called his mother from his hospital room and told her, "Make sure you pray before you go to sleep." In the morning, he was dead.

That's a dramatic example, yes, but the evidence is more than just anecdotal. A March 10 commentary in the *Wall Street Journal*, titled "Medicaid Is Worse Than No Coverage at All," surveys the scientific literature. The article's author, Scott Gottlieb of the New York University School of Medicine, writes that a 2010 study of throat cancer "found that Medicaid patients and people lacking any health insurance were both 50 percent more likely to die when compared with privately insured patients." A 2011 study of heart patients "found that people with Medicaid who underwent coronary angioplasty were 59 percent more likely to have...strokes and heart attacks, compared with privately insured patients. Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn't have any health insurance at all." A 2010 study of major surgical procedures "found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death."

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Finally, Gottlieb adds this:

> In all of these studies, the researchers controlled for the socioeconomic and cultural factors that can negatively influence the health of poorer patients on Medicaid.
>
> So why do Medicaid patients fare so badly? Payment to providers has been reduced to literally pennies on each dollar of customary charges because of sequential rounds of indiscriminate rate cuts.... As a result, doctors often cap how many Medicaid patients they'll see in their prac-

tices. Meanwhile, patients can't get timely access to routine and specialized medical care.

AT THE SAME TIME as it's performing poorly for patients, Medicaid is a central component of out-of-control entitlement spending that threatens to bankrupt the nation.

Under a federal formula, the feds pay for about 60 percent of program costs, and states pick up the balance. That means ballooning costs present crises to both levels of government.

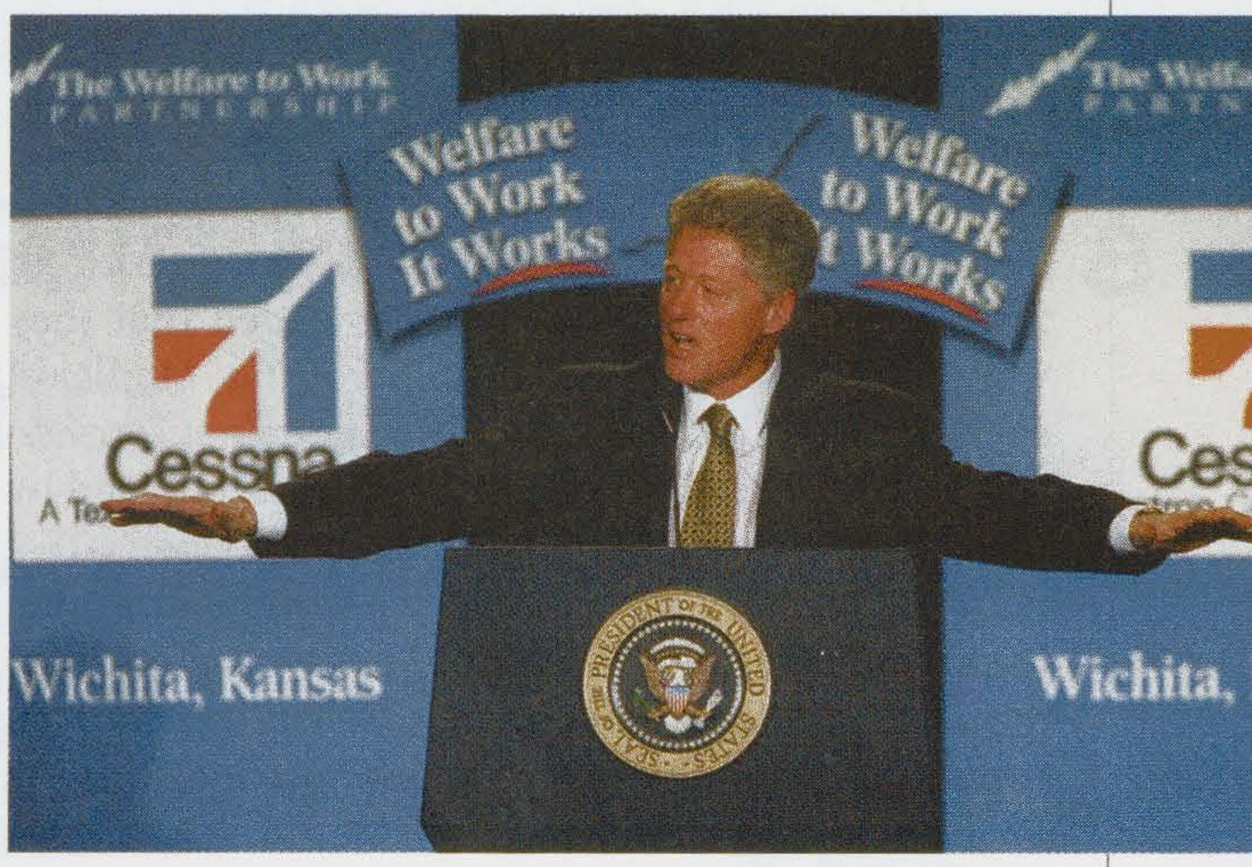
On the federal level, President Obama's budget projects Medicaid costs will total nearly $4.4 trillion over the next 10 years alone, with annual costs soaring by 127 percent to nearly $600 billion by 2022. State liabilities run roughly an additional two-thirds more. The National Association of State Budget Officers reports that states already spend more on Medicaid than anything else, even K-12 education. Together, federal and state spending for Medicaid will total more than $800 billion per year by 2019, according to the federal Center for Medicare and Medicaid Services.

Those numbers reflect an expectation that the Medicaid rolls will swell. Today the program serves an estimated 60 million people. Through the genius of Obamacare, that figure could hit 85 million soon and reach nearly 100 million by 2021, according to the Congressional Budget Office. (The big lie in Washington is that Obamacare will put millions more on the Medicaid rolls, yet somehow still reduce the budget deficit.)

BOTH OF THESE PROBLEMS can be solved by extending to Medicaid the enormously successful 1996 welfare reforms.

To refresh memories: Those reforms dealt with a New Deal-era program called Aid to Families with Dependent Children (AFDC), which, like Medicaid, was previously funded through a federal-state matching formula. The result was that the federal government effectively paid states to increase spending, because the more they spent on AFDC, the more federal dollars they received.

The 1996 reform returned to each state its share of federal AFDC spending, this time as a lump sum. The key was that these block grants were finite. If a state's new program cost more, the state had to pay the extra costs itself. If the state's program cost less, it could keep the savings. The reformed program was renamed Temporary Assistance to Needy Families (TANF).



The reform was opposed bitterly by the liberal welfare establishment. That view was well expressed by Senator Daniel Patrick Moynihan, the Urban Institute, and others who predicted that the reforms would produce a "race to the bottom" among states, and that within a year a million children would be starving.

But quite to the contrary, the reform was shockingly successful and exceeded even the predictions of its most ardent supporters. The old AFDC rolls were reduced by two-thirds nationwide. Success was even greater in states that most aggressively pushed work for the able-bodied, as those formerly on the program went to work, or married someone who worked.

By 2006, total federal and state spending on TANF was down 31 percent in real dollars from AFDC spending in 1995, and down by more than half of what it would have been under prior trends. At the same time, because the new program encouraged work, the incomes of formerly dependent families rose by 25 percent, and poverty among them plummeted. "[B]y 2000 the poverty rate of black children was the lowest it had ever been," reported Ron Haskins of the Brookings Institution in his book *Work Over Welfare*.

THE SAME MAGIC could work for Medicaid if Congress replaced matching funds with fixed, finite block grants. Each state would then be free to use the money for its own redesigned health care safety net, in return for work from the able-bodied.

There's an example in Rhode Island, which in 2009 received a broad waiver from federal Medicaid requirements in return for a five-year fixed cap on federal financing. The state turned to managed care,

competitive bidding by health care providers, and comprehensive case management by private insurers. It shifted more long-term patients out of nursing homes to home and community environments.

The Lewin Group, a top health care consulting firm, studied the reforms and concluded that they were "highly effective in controlling Medicaid costs" while improving "access to more appropriate services." Indeed, the state's costs were reduced by nearly 30 percent in the first 18 months alone.

Alternatively, states could use their block grants to provide vouchers that would help poor residents pay for private health insurance of their choice. Such vouchers would free the poor from the Medicaid ghetto and enable them to obtain the same coverage as the middle class. Among their choices would be Health Savings Accounts (HSAs), which maximize consumer control over health care dollars, rather than insurance company control. HSAs, backed up by catastrophic health insurance policies, provide powerful, proven incentives for consumers to reduce costs themselves, so as to preserve future funds.

Like modernized AFDC (TANF), Medicaid vouchers should be subject to a work requirement for the able-bodied. The Children's Health Insurance Program (CHIP), which helps insure kids from modest-income families that earn too much to qualify for Medicaid, should be rolled into the block grants as well and administered by the states.

Block grants would provide each state with incentives to adopt long-overdue changes to reduce health costs, such as tort reform and the elimination of state-mandated benefits in favor of maximum consumer choice.

SUCH FUNDAMENTAL entitlement reform is now mainstream within the Republican Party. Paul Ryan included Medicaid block grants in his 2012 and 2013 budgets, both of which passed the Republican-controlled House. The CBO calculates Ryan's reform would save $810 billion over the first 10 years. Equally important, the poor would gain the enormous advantages described above.

But the model bill is H.R. 4160, the State Health Flexibility Act, co-sponsored by, among others, Reps. Todd Rokita (R-Indiana), Tim Huelskamp (R-Kansas), Paul Broun (R-Georgia), and Jim Jordan (R-Ohio). It represents the dream legislation of Reagan and his top welfare policy advisor Robert Carleson, and was developed with assistance from the Carleson Center for Public Policy. Under the bill, the federal block grants would not be provided by the Department of Health and Human Services, but directly by Treasury, which would prevent the HHS bureaucracy from doing mischief through interpretive regulation. Moreover, as with the 1996 AFDC legislation, the block grant funding would be kept flat, rather than indexed to grow with population and inflation, as in Ryan's budget. Consequently, the CBO scores this bill as saving $2 trillion over the first 10 years.

Every GOP presidential candidate endorsed the idea of Medicaid block grants, including apparent nominee and consequently party leader Mitt Romney. But Barack Obama and the dead-end Democrats are fiercely opposed. Obama called Ryan's Medicaid block grants "the largest cut to Medicaid that has ever been proposed." Would it be accurate to say the 1996 AFDC reforms "cut" welfare by 50 percent? How can it be rational to oppose reforms that would reduce costs while providing better care through choice, incentives, and competition? Opposition would only make sense if you were ideologically opposed to private, free markets rather than government and taxpayer dependency.

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