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Solutions to the Medicaid Crisis in New Mexico

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Solutions to the Medicaid Crisis in New Mexico:

New Mexico's Medicaid program is projected to absorb 80 percent of the growth in state revenues in FY 2004. Beyond that its growth shows no signs of slowing. It is one of the most generous Medicaid programs in the nation. How can we provide meaningful help to the poor without busting the budget?

Goals of this Study

This study looks at the big picture. How can Medicaid be restructured so that it somehow fits into the budget for the longer term while providing ample health care aid to the poor? The key questions are:

- Why is Medicaid so expensive?
- How rapidly will the costs grow if nothing is done to change the program?
- What are the options for controlling costs and how will these options affect the health and well-being of Medicaid recipients?
- What are the larger issues facing New Mexico and other states that stem from the federal government's approach to Medicaid?

This study will not get into the details of Medicaid operation except where necessary to clarify seeming inconsistencies. It is an extremely complex program in its design, funding, and operation. Rather, we will examine the larger issues in an effort to provide guidance and context for the legislation that is so badly needed.

Background

2002 Legislative Session

When the New Mexico legislature debated the state's budget in early 2002, it soon became apparent that Medicaid was the most cumbersome and intractable item. Medicaid had been growing for years and threatened to crowd out important programs unless it could be contained. Long term, the policy dispute is over how much health care aid is desirable for Medicaid's many and varied beneficiaries versus how much of the program's snowballing costs the state can afford. Primarily because of the Medicaid dispute, the governor and legislature were unable to agree on a budget. Over objection of the governor, an extraordinary legislative session later in the year funded Medicaid for FY 2003 without any real changes in its structure.

Recognizing the potential for future budget busting by Medicaid, the legislature and the governor did agree that Medicaid's budgetary ills must soon be cured. So a "declaration of emergency" established a "Medicaid Reform Committee" to study the problem. The results of this committee have recently been released, and the results are disappointing. No significant changes in program rules are recommended.

Medicaid as Part of the Larger Welfare Picture

Medicaid is but one element of overall federal and state efforts to help the poor. There seems to be a general consensus that government ought to be assuring adequate levels of health care, housing, food, energy and cash assistance for the poor. An obvious problem arises in defining exactly what constitutes an "adequate level" of help – people have a wide range of opinions about "adequate." The wide range of opinions would be much narrower if welfare did not modify behavior in ways that are harmful. But modify behavior it does. We hope to help inform those opinions, at least with respect to Medicaid, by looking at how Medicaid assistance promotes irresponsible behavior. In New Mexico Medicaid eligibles get the equivalent of the Lexus of health care; that is the standard defining "adequate level" of help that has emerged in New Mexico's political process.

Economic Fundamentals

We approach the issues facing Medicaid from the perspective of basic economics, starting from certain fundamental principles and questions:

- We must understand the *incentives* affecting the people eligible for Medicaid. How is the demand for health care affected? In the larger picture, how much does the implicit tax on earned income affect Medicaid recipients' incentives to work and earn income? We must also understand the *incentives* affecting health care providers under Medicaid. How is the supply of health care affected?
- Which services covered by Medicaid follow *sound principles of insurance*? And where they don't, what is the implicit value of services transferred to recipients and how much does that cost?
- Is it really necessary to mandate benefit packages for all recipients? How might we restructure Medicaid to allow *choices of benefits* by recipients and how would that affect Medicaid costs and recipients' health?
- Perhaps overriding all these considerations is that of *scarcity*: "There's no such thing as a free lunch." Scarcity is a fundamental problem faced everywhere, even in this rich nation. You cannot obtain more health care without sacrificing something else. We economists may seem heartless when we raise this unpleasant reality. Like everyone else, we would like people to have as much health care as they need for "free". But that is not

how the world works. An example of the confusion resulting from failure to recognize scarcity is how often we hear that the three-for-one dollar subsidy provided by the federal government for Medicaid is “free” money for the state.

Medicaid’s Size and Complexity

The sheer size of Medicaid is not well understood by the public. Few are aware, for example, that a family of four with income of \$42,540 qualifies¹ for “free” medical care, or that nearly 20 percent of the population gets Medicaid benefits. One of the goals of this study is to enhance public awareness of how the program operates.

Legislators are increasingly aware that vital state functions in education, transportation, and law enforcement are being squeezed by the ever-mounting budgetary costs for Medicaid. They need to determine just what New Mexico will give up if it continues to let Medicaid grow rapidly, as it will if nothing is done.

Medicaid in New Mexico

The purpose of Medicaid is to finance health care for children in relatively low-income families and for the elderly poor and disabled. Despite the aforementioned budget crunch, however, there are efforts underway to expand New Mexico’s Medicaid program beyond its usual mandate to allow not just children, but relatively low-income adults to qualify (State Coverage Initiative).

At last count, 382,000 New Mexicans were receiving Medicaid. Of these, roughly 218,000 were children. Income is the main criterion for eligibility, though it is more complicated than that: There are 34 eligibility categories that take ten pages to describe. Regulations pertaining to health care providers are even more complex, covering in detail what services are mandated and how much the state will pay for each service. Medicaid is financed by the state, but the federal government pays about 75 percent of total costs by matching state spending in the ratio of three dollars for every dollar out of the state’s general fund.

Medicaid is an entitlement program meaning that once the rules are in place the state undertakes to pay whatever it costs to meet all of Medicaid’s expenses. The eligibility rules determine how many people may receive benefits, and those eligible are free to seek medical care according to their needs. Thus, the state has only a loose grip on costs.

These costs are large and growing. Over the past decade, Medicaid expenditures grew at an average annual rate of 11 percent, almost double the growth rate of the state’s budget during this period. From 1991 to 2001 New Mexico experienced more rapid growth in Medicaid than any other state in the union.

¹ In this case, only children under age 18 are eligible and a small copayment is required.

For fiscal 2003, the legislature appropriated \$334 million for Medicaid, about nine percent of the state's general fund (not counting the federal match of over **one billion dollars**). But even this fell short. By October of 2002 the Human Services Department announced that an additional \$76 million was needed for the next year's budget, and another \$40 million will be needed just to cover this year's shortfall. At this point it appears that additional costs of Medicaid will absorb about 80 percent of the expected increase in state revenues.²

Medicaid is stressing budgets across the nation

Medicaid serves 35 million people nationwide. Medicaid costs are outpacing total state expenditure growth by a considerable margin. In 2002, it is estimated that total state spending grew by 6.6 percent while Medicaid surged by 11.7 percent.³ Medicaid accounts for around 20 percent of total state expenditures, second only to primary and secondary education.⁴

As in New Mexico, Medicaid expenditures often grew considerably faster than states had estimated. According to figures from the Centers for Medicare and Medicaid Services (CMS), Medicaid growth will remain strong through 2011, driven largely by increasing costs of enrollment growth. For any given enrollment, Medicaid costs will be driven further upward by the cost of drugs.⁵ Some have predicted that Medicaid costs could triple by 2010.⁶ Medicaid will implode if nothing is done about its long-term care provisions before the baby boomers become senior citizens. Every serious analysis sees Medicaid costs rising much faster than revenues.

Other states are searching for some way to stop this budgetary juggernaut, and some are ahead of New Mexico in finding solutions. All of the viable approaches involve greater dependence on market-based approaches.

² *Albuquerque Journal*, October 24, 2002, page D3.

³ "Medicaid to Stress State Budgets Severely into Fiscal 2003, p. 1," National Association of State Budget Officers, March 15, 2002.

⁴ *Ibid.*, p. 1-2. This percentage includes the federal match to states' general fund.

⁵ Cited in *ibid.*, p. 2.

⁶ American Legislative Exchange Council, *A Medicaid Primer*, 2002.

Why is Medicaid So Expensive?

Why has New Mexico's Medicaid program become so costly? For two basic reasons:

- The number of people being served has grown steadily, and
- The expense per person has grown rapidly, because of nationwide increases in the cost of health care.⁷ One bit of good news is existence of partial market-like competition among the three managed-care providers in the Salud! program. As a result, New Mexico has done a little better than the national average at controlling health care cost inflation.

Medicaid is an entitlement program and therefore has built-in sources of growth. Anyone who qualifies gets the benefits, and the state is obligated to pay whatever these benefits cost. Entitlement programs are inherently costly because they hold out powerful incentives for people to take advantage of their benefits. When the government offers “free” money, goods, or services, rational people accept them. Every entitlement program—Food Stamps, Medicare, Social Security, and Earned Income Tax Credit, to name some of the largest—has grown enormously since its inception, often to levels far above what was originally envisioned. Medicaid is no exception.

After an entitlement program is put into effect, it inevitably expands. Over the years, more people become aware of its availability, and costs grow as more and more of the eligible people take advantage of it. Moreover, after partaking of its benefits for a time, people adjust their own behavior to the existence of the program in ways that increase their benefits, which therefore increases program costs. For example, if Medicaid benefits are made more generous, people and firms reduce the amount of health insurance for which they themselves pay; and Medicaid ends up crowding out privately provided health insurance.

Political force builds and solidifies. After a large number of people become beneficiaries, they and the army of “advocates” and state and MCO bureaucrats who administer the complex rules become a political force strong enough to influence legislators to make the program ever more generous.

New Mexico's Medicaid program has grown from about 87,000 enrollees in 1981 to about 316,000 in 2001 and 382,000 by the end of 2002. This is an average annual growth rate of 6.7 percent, exponential growth sufficient to double enrollment in eleven years if continued. At this point, around 18 percent of the state's population is enrolled in Medicaid, over 20 percent if the entire year is

⁷ The price of medical services has grown in New Mexico, as it has nationally, but this has proved to be less of a cost factor than growth of the number of recipients and the generosity of the program.

considered.⁸ Even if the benefit package remained fixed, the cost of the program would be growing considerably faster than New Mexico's tax revenues.

But the costs per recipient have also grown rapidly—at an average annual rate of 4.1 percent over the past ten years. Medicaid rules at the federal level give states some leeway in designing their own Medicaid rules beyond the core of federally-mandated benefits and minimum eligibility criteria. In virtually every instance New Mexico has used this leeway to choose the most costly option among those available. Some of these options are simply related to the size of benefits, and other aspects of program design become costly because they ignore free market principles and basic economics.

Even the huge budgetary costs of Medicaid do not tell the whole story. Other costs involve hard-to-measure misallocation of resources. For example, since Medicaid is a very valuable entitlement, and since eligibility depends upon one's income, there is a strong incentive to reduce one's work effort enough to get within the income limits. Another example: Many firms are willing to give low and mid-income workers health benefits, but with Medicaid so generous why should they bother?⁹ The state winds up subsidizing private companies while crowding out private insurance. New Mexico's doctors also bear large costs, since Medicaid's cousin Medicare sets a standard for reimbursement rates that in many cases are less than the costs of treating patients.

Let us examine some of the specific reasons for Medicaid's growing cost to New Mexico's taxpayers:

Third Party Payments and Lack of Personal Choice

When a typical person buys something with her own money, she shops around and is careful to buy just the amount that she feels she needs from whomever she feels gives her the best deal. She tries to make best use of the limited amount of money she has, doing the best she can within the limitations of her income and assets. Even with medical services, there are degrees of need: treatment is costly, and one doesn't seek treatment unless the perceived illness is bothersome enough to make treatment worth its cost.

New Mexico's Medicaid program is designed to remove this aspect of careful shopping on the part of its consumers. There are little or no copayments or cost-sharing requirements, let alone premiums; Medicaid pays almost everything from the first dollar. Since Medicaid beneficiaries are under the illusion that medical services are "free," those under Medicaid may consume all the treatment and medicine they want, for any malady however trivial. One doctor told us that his

⁸ Enrollees often let their enrollment lapse while the kids are healthy, but they can reenroll with ease when necessary.

⁹ It is often noted that New Mexico has one of the lowest proportions of families with health insurance. But is this evidence of the need for state-paid health care, or the result of the very generous provision of health care that already exists?

Medicaid patients often make appointments and then fail to show up, suggesting that the reason for the appointment was of little consequence.

Related to this, doctors may (subject to rules guiding Managed Care Organizations regarding formularies) prescribe large amounts of drugs and give extensive treatment knowing that they will encounter little resistance from patients for whom this care is costless.

The net result of this system is to greatly expand the costs to the state and federal governments. Indeed, Medicaid's benefit package is so generous that it is impossible to buy such a plan on the open market because no rational insurer would expose itself to the unlimited liability that an open-ended plan would entail.

Of course, the whole point of Medicaid is to make medical treatment available to those who have comparatively more difficulty affording it. But in any insurance policy that one can buy there are options to save on the cost of premiums by agreeing to a deductible amount, limits on costs, or some such mechanism that makes the insured person responsible for at least some of the costs. This injects a healthy dose of reality (she no longer treats health care as "free") into the insured person's decision-making process and therefore puts a brake on consumption and costs. For example, private sector health insurance reduces the premium by about 30 percent when the deductible is increased from \$250 to \$1000.¹⁰ Any approach to limiting the cost of Medicaid should consider also the requirement for copayments.

A more fundamental issue arises: Why does the government provide medical services directly rather than the financial means to acquire medical services? Economists are generally convinced that the most efficient way to alleviate poverty is to give poor people money, rather than various bundles of goods chosen by the government. Then, since people's wants and needs differ, they are free to spend the money on exactly what they choose—food, housing, transportation, clothing, or whatever. Often, however, the government dons its paternal cap and decides exactly which goods and services people should consume. In virtually every case, people would be better off if they were given the cash equivalent of the government-provided goods and left to seek out the best package in the market.

Since Medicaid gives eligible people all the medical services they want, it is a misnomer to call it "insurance." Medicaid strays far from good principles of real insurance. Real insurance forms a risk-sharing pool that provides protection against low-probability, high-cost events such as advanced cancer treatments and bypass surgery. Medicaid covers these things but also relatively inexpensive and common items like eyeglasses and routine dental care. It is akin to a

¹⁰ There is no private sector example of a Medicaid-like insurance plan with no deductible and unlimited coverage, so no strict comparison is possible.

program that allows you to fill your car's tank with gasoline whenever you want and is called "Empty Gas Tank Insurance."

It would be much less expensive to make Medicaid coverage a true insurance policy. Then we could use some market-based alternative, like medical savings accounts, health reimbursement arrangements, vouchers or refundable tax credits to let Medicaid eligibles buy commercially available health care packages. It is not simply a matter of giving less coverage, but of inducing people to economize on the amount of money they want to spend for the type of insurance they need.

The "Three-dollars-for-One" Effect

The federal government contributes three dollars for every dollar budgeted by the state for Medicaid. The federal share is determined by comparing the state's economy to the national average. Since New Mexico's economic performance is consistently well below average, it receives somewhat higher matching contributions than do most other states. The federal contribution is called the Federal Matching Assistance Percentage (FMAP), and is (about) 75 percent for New Mexico.

This matching grant results in higher Medicaid spending by New Mexico, which is exactly what it's designed to do. As is noted by those who argue for higher Medicaid spending, it's like having a clearance sale on Medicaid at 75 percent off. How can we pass up such a deal?! But even the 25 percent that the state itself has to pay has grown into a massive burden. Like New Mexico, most other states are finding that this irresistibly great sale on Medicaid is breaking their budgets.

The FMAP is a Faustian bargain if there ever was one. The 75 percent federal match has to come from somewhere, and that source is ultimately taxpayers' pockets. It is impossible to trace any given dollar of federal spending back to its source, as it all goes into and comes out of one (big) pocket. But whatever Washington sends to the states has first been taxed away from people in those states.¹¹ New Mexico gets a big check from Washington, but *New Mexico's taxpayers must pick up the tab for the Medicaid match in the other states.* So in effect each state winds up paying for its own Medicaid program under the illusion that 75 percent of spending is "free" money. It may not come out evenly, state by state, but it's close. Rather than being a source of "free" money, the FMAP has created a destructive free-for-all among the states. Looked at this way, the burden on New Mexico's taxpayers is more like 27 percent of total state spending!

Moreover, buying into the Medicaid system forces states to forgo choices they might have thought were protected by the principle of states' rights. Recent

¹¹ In addition, the federal government takes a healthy cut for administrative purposes before returning the remainder to New Mexico.

decisions by Circuit court judges, however, have ruled that plaintiffs seeking benefits can sue states for benefits they think they should have, i.e. that the states' rights "immunity doctrine" does not apply once states have opted into Medicaid. The circuit court judge explained that if states didn't want to follow federal rules they should have opened their own programs.¹² So the FMAP essentially results in federal control of the states' 25 percent contribution. Clearly, this opens the door for higher costs mandated from Washington.

Thus, the "three for one" FMAP clearly adds pressures to New Mexico's costs (and other states' costs!), despite the illusion of "free" money from the federal treasury. In the "conclusions and recommendations" section of this report, we offer some approaches to fixing this problem; but it's not something New Mexico can do much about on its own.

Fraud

Another reason for soaring Medicaid costs is the fraud rake-off. No one knows the full extent of fraud in New Mexico's Medicaid system, but indications are that it is substantial. The very design of the program makes it a target for abuse. According to the U.S. General Accounting Office, "Medicaid is highly vulnerable to fraud because of its size, structure, target population, and coverage."¹³ The GAO gives a rough estimate that fraud may drain as much as ten percent of the program's funding. A report published by the Texas Public Policy Foundation estimates that in the Texas Medicaid program fraud comprises about 30 percent of program costs.¹⁴

Why so much fraud? Mainly because of the way Medicaid is set up and managed. Ineligible people can get in without too much trouble, and once in can misuse the system, sometimes in concert with unscrupulous providers.

Eligibility depends on income, which is easy to underreport and hard to verify. Even if underreporting is discovered, penalties are usually light even in the unlikely circumstances when prosecutors undertake a case of client underreporting. Prescription drugs are an appealing target for the dishonest; typical schemes involve druggists adding various medications to customers' orders and then selling them to someone else at market prices. Many other illegal ruses are possible under the relatively light Medicaid enforcement regime common in most states. In reviewing the state's "flexibility," use of "disregards," and "presumptions of eligibility;" we were struck by the stark contrast between slack enforcement of Medicaid rules and much tougher enforcement of IRS rules. Is it any wonder that there is so much fraud? The fraud found so far may be the tip of a bigger fraud iceberg.

¹² *Albuquerque Journal*, May 27, 2002, p. A3.

¹³ U.S. General Accounting Office, 1994. It is somewhat depressing that the most recent GAO look at fraud in Medicaid is now eight or nine years old.

¹⁴ Wohlgemuth, 2002, p. 14.

Unfortunately, no one has rigorously measured Medicaid fraud in New Mexico. While we have no reason to say that fraud is worse in New Mexico than elsewhere, neither do we see any likelihood that it will be eliminated or even reduced as the program continues to grow.

Administrative costs

State Administration

Medicaid is, by its nature, costly to administer. Every application must be evaluated, as too must claims; and the process of getting money to medical providers is also labor-intensive. According to published figures, administrative costs were about \$77.2 million in 2001, or about 5.3 percent of New Mexico's budgeted costs.¹⁵ We find these figures suspiciously low given the complexity of Medicaid rules and accounting.

Is New Mexico's program well managed? Various reports indicate that it may not be. According to the *Albuquerque Journal*¹⁶ "a new state audit has discovered that an accounting problem first identified two years ago has cost New Mexico's Medicaid program more than \$5 million in taxpayer money." It is alleged that the program overpays some providers and fails to keep adequate records of what it has paid. Filtering through the political rhetoric, it is difficult to tell how much of this problem is attributable to the complexity of the eligibility rules and how much is attributable to basic accounting problems within HSD.

Many believe that Medicaid is not well positioned in the state's administrative structure, to the detriment of its operational efficiency. In 2001, the Legislative Finance Committee endorsed creating an agency whose sole job would be to administer Medicaid. The proposal called for breaking up the much-criticized Human Services Department and creating a "Medical Assistance Department" to get a better grip on the flow of Medicaid dollars and services. The reorganization was never enacted, but the concerns remain. Without fundamental reform, however, management reorganizations may be akin to rearranging the deck chairs on the Titanic.

Doctors' Administrative Burden

Doctors themselves face an enormous administrative burden in complying with Medicaid rules and seeking payment for health care services provided. We have not conducted an audit of Medicaid practitioners' clinics, but it is not unreasonable to assume, based on published reports, that roughly 30 percent of their resources go to complying with Medicaid's complex administrative burden.

Thus, in considering the value of Medicaid to the state's taxpayers, one must recognize the substantial gap between what is taken from taxpayers and what

¹⁵ FY 2001 Reported Medicaid and SCHIP Expenditures

¹⁶ *Albuquerque Journal*, May 9, 2002, p. 1.

goes to deserving Medicaid enrollees. Evidence suggests that Medicaid does not have a record that should inspire great confidence that taxpayers' money is being spent as carefully as it should. And that's putting it mildly.

Growing costs of medical services

The costs of medical services have grown rapidly in recent years. Fees for Medicaid services are set by the state, but they have had to grow more or less in keeping with national trends. The Bureau of Labor Statistics reports that the cost (as measured by the producer price index) of physician office visits in 2001 was 119.1 percent of what it was in 1993. Similarly, the cost of general medical surgical hospital visits in 2001 was 123.4 of its 1992 level. The cost of pharmaceutical preparations in 2001 was a full 314.5 percent of what it had been in 1981.

Expensive clientele

The population covered by Medicaid has greater medical needs than the population at large. About 70 percent of Medicaid recipients are children. Of the adults, the great majority is elderly or disabled; and they are the most expensive insurance risks. Moreover, there is probably an inverse relationship between income and health (unhealthy people don't earn as much as healthy people), which also boosts health costs of the average enrollee. There is not much that can be done about these reasons for high costs; they are inevitable with a program that is designed to help poor people with health problems.

Popularity with recipients, legislators, and administrators

Medicaid has reached the point where it has strong political support and the consequent pressures for growth. With close to 20 percent of the state's population now eligible, it is no wonder that lawmakers view expanded benefits as a source of votes. The legislature in the late 1990s made several changes that have greatly expanded Medicaid's eligibility criteria and benefits.

Administrators have the incentive to expand the program and use various means of encouraging membership. For example, people are allowed to sign up in schools, clinics, and hospitals rather than at the "welfare office." Advertisements and "enrollment fairs" help people sign up. Children can get "presumptive eligibility" giving them coverage while their applications are being processed.

Prospects for Medicaid's Growth

Medicaid has grown rapidly for the reasons given above, but what about the future? What are the prospects for the next few years? Can we expect costs to level off, or will the explosive growth continue?

The fact is that no one knows the answer to this with any precision. Indeed, in the past the state has had only a vague idea of how fast costs were going to grow and hence has had no real basis for getting a grip on the Medicaid budget.

What is the outlook for costs? Let us consider the main sources of growth, and assume no significant changes in policy.

Eligibility. Some growth is certain, simply because the key parameter of eligibility—the poverty line—is likely to grow somewhat from year to year in nominal terms. That means the budget will have to grow – it will ratchet up with inflation. Eligibility will also increase with New Mexico’s future population growth, which we would project to be at least one or two percent a year. Thus, we would expect the number of eligible families to increase somewhat in the years to come.

Enrollment. This is likely to be a continuing source of growth. It would appear that most of those eligible are now enrolled, but there is probably still some room for growth.¹⁷

Intensity of use. If current trends continue, people already enrolled will gradually increase the services they use, so the cost per capita will rise. If the cost per capita is not allowed to rise, services will be rationed by waiting. In that case we would see the gate-keeping function of MCOs get more visible and patients will have fewer options for choice of treatment and caregivers.

Costs of services. The cost of medical services continues to grow nationally and in New Mexico. While the state sets the reimbursement schedule, at some point it will have to raise the amount that doctors receive for their services. Costs of prescription drugs will continue to grow, but they are subject to possible federal actions that may slow this growth. Currently New Mexico reimburses its Medicaid providers at the third most generous rate in the nation¹⁸, so we may see reluctance by the legislature to increase these costs. In that event we would see more rationing by waiting as described above.

Federal mandates. The federal government will be under a lot of pressure to take actions to reduce Medicaid costs, but it is uncertain whether this pressure will have any effect. If history is any guide, revision of Medicaid rules will likely result in greater costs at the state level.

Every one of these key cost factors cited above is headed upwards, either a little or a lot. Thus, there is no doubt that costs for Medicaid are still headed upwards, on the order of at least five percent to possibly 10 percent growth per year for the rest of the decade. This inevitable growth demonstrates the need for a long-term look at the problem, rather than the annual fire-fighting exercise.

¹⁷ This item is fraught with uncertainty. State officials did not provide any information.

¹⁸ LFC Newsletter of November 2002.

Implications for policy

Based upon this analysis of why Medicaid costs are rising so steadily—and will continue to rise—we can put forth these implications for the general approach to dealing with the problem:

Do nothing. A recipe for fiscal disaster. Within a year state spending would exceed revenues, and the deficit would grow steadily, driven by Medicaid costs. Since law requires a balanced budget, all other spending would have to be cut each year for the foreseeable future.

Raise taxes. Just as bad. While it would be possible to cover a year or two's worth of Medicaid growth with higher taxes, this would in no way solve the problem. Raising taxes would result in another form of fiscal disaster and would ultimately fail, as taxes would have to be raised each year indefinitely. As is well known, New Mexico's taxes already exceed those of its neighboring states and are a prime cause of the state's poor economic performance.

Call for improvements in efficiency. Yeah, right. Even if such improvements were made, they would have little if any effect on the growth rate of Medicaid costs and, at best, would only delay the day of reckoning.

Cut back on reimbursement rates to doctors. Another bad idea. This won't provide more than marginal relief for a short time, as doctors have the option of refusing Medicaid patients and will do so increasingly if their incomes are squeezed further.¹⁹

Cut back on benefits. Now we're getting somewhere. But this approach, while necessary, is not a complete solution. Even if the number of eligibles was frozen at current levels, for example, costs would continue to increase for the reasons listed earlier.

Think of a leaking boat. Bailing out 10 gallons of water will help keep the boat afloat for a while longer; but before long more bailing will be needed. Indeed, bailing will be needed as long as the leak remains unplugged. The situation with Medicaid is similar: Cutbacks of benefits would be required each year as long as the current Medicaid framework is in place.

Reform the system. The target should be a Medicaid system whose costs grow no faster than state revenues and which still gives a safety net of health insurance to the truly needy. This system may be radically different from what

¹⁹ Supposedly the three MCOs in Salud! must accept Medicaid patients. But as demand for Medicaid services exceeds supply, their gate keeping function will deny some patients care perforce.

now exists, and it will take careful planning. But other states are taking this kind of approach²⁰, and it appears promising. And what is the alternative?

Economic Principles for Reform

Something must be done to contain the large and growing costs of Medicaid. Current rates of growth are unsustainable. As the saying goes, “Things that can’t go on forever, won’t.”

Yes, some people will get a little less. That’s inevitable given the budget situation and the certain growth of Medicaid costs if they are not contained. But if we can make medical services correspond more closely to the actual needs of the lowest income families, then the real losses will be quite small.

If we take it for granted that Medicaid is a justifiable function of government, and that it is here to stay in some form or other, we have these basic approaches to solving the budgetary crisis that Medicaid has brought to New Mexico:

- Cut back on eligibility and benefits.
- Redesign the benefit structure so that people have incentives to use the system more efficiently.
- At the federal level, overhaul the “three-for-one” FMAP method of financing the program.
- Search for a new model of medical care for low-income families.

In one sense, the problem looks easy: Simply cut back on the size of the program by tightening eligibility requirements and by reducing the scope of benefits. “Give us a budget, as tight as you like, and we can cut Medicaid to fit it. Mission accomplished.”

But this straightforward approach is, in our view, inadequate and inadvisable. While certain cost-cutting measures must be a part of any reform package, they should not be the only steps taken. For one thing, because of the inexorable growth of costs for any given program specification, the legislature would have to revisit Medicaid practically every year. Also, a big item like Medicaid needs to be considered in the context of projected tax revenues and other budget items, which generally augur for a tight budget for some years to come.

Far better to take a longer term look and design something that will still be workable and affordable five or ten years from now. Moreover, simply chopping away at eligibility and benefits is likely to conflict with the basic goal of providing health benefits to the poor. We need a scalpel, not an ax, and we also need to

²⁰ Though a recent Kaiser report doesn’t name the specific states, fully 17 states report that they are increasing (or plan to increase) their beneficiary copayments. 27 states are pursuing eligibility cuts and restrictions and 25 states are reducing benefits.

take a fresh look at the whole health-care-assistance approach at both the state and federal levels.

With this as background, let us consider the options, starting with adjustments to the existing system that would reduce costs:

Tighten eligibility: Several options for cutting back eligibility are obvious. The simplest would be to reduce the eligibility income thresholds to something considerably less, something more in keeping with what other states mandate. For example, Medicaid eligibility for children in families of four could be cut from 235 percent of the poverty line to 185 percent of poverty. This would cut off aid to those with the highest incomes and would be in keeping with providing medical services to those who can least afford them.

Another way to reduce the costs of Medicaid is to create a sliding scale of benefits, with smaller benefits going to those with higher incomes. This would reduce the inefficient “notch effect,” whereby people whose incomes place them on the verge of ineligibility are induced to cut back their work effort or to cheat when reporting their income. In other words, a family with no income would get the full Medicaid benefit, and as income rose the benefit would be phased out gradually.

But there’s a problem with this. If Medicaid has a phase-out rate of 30 percent (each dollar of earned income reduces benefits by 30 percent) this 30 percent adds to the overall effective income tax rate the family faces. Add that to the high rate imposed by the Earned Income Tax Credit, the state income tax, food stamps and possibly some kind of housing assistance; and the family may face an effective marginal income tax rate of nearly 100 percent (or more), i.e., for every extra dollar they earn they have to give up nearly a dollar’s worth of benefits. That’s crazy. The point is that the legislature needs to look very carefully at the effective income tax rate that results from Medicaid reform, and they need to do it in conjunction with the effective income tax rates of other welfare programs as well as actual rates of taxes on income.

Reduce benefits: As already noted, New Mexico’s version of Medicaid is generous to a fault. Nearly everything is covered—eye glasses, replacements for broken eyeglasses, dental care, drugs: the works. If it were made to resemble even the more generous of the insurance programs offered in the private market a great deal of money would be saved.

Impose a deductible and copayments: Require the patient to pay the first \$100 (or some amount) of the year’s medical costs, and require some low copayment for each visit. This feature is nearly universal in private programs. It not only cuts down on state’s costs for a given medical procedure, it gives people the incentive to forgo professional medical treatment for the least serious maladies that could be treated at home or with over-the-counter medicines.

All of these options have the beneficial effect of inducing people to pay more attention to preventive measures—diet, exercise, avoidance of smoking, reducing exposure to the sun—that in the long term cut down on the need for medical care. Several doctors we’ve interviewed say that their main criticism of Medicaid is that it has no element of preventive medicine or encouragement of more healthful lifestyles.

All of these options call for a tightening up within the current framework of Medicaid. With sufficient application of such options, Medicaid costs could be reduced to virtually any amount desired, still targeting the benefits at the poor and requiring the higher income recipients to pay at least some of their health care costs.

Change the 3-for-1 federal matching formula to block grants: The federal government has rigged the system so that states overspend. The system gives states a strong incentive to spend more money than they would if it were all coming directly from their own citizens. So long as this incentive is around, states will not be able to come to grips with the problem; there will always be someone to say, “we can’t give up this ‘free’ money.”

The cure for this distorted incentive to overspend is to convert the FMAP formula into a system of block grants which total about the same amount as they do now but which leaves states free to set up their own plans and to see that a dollar spent on health care really costs a dollar.

Changing this system would be a major political shift that could take years of concerted effort to accomplish. All the states would have to work together to get Washington to make the change. But let’s at least start debating it now.

Do NOT raise taxes: According to press reports, raising taxes is the preferred option of some legislators.²¹ Suggestions include increased taxes on tobacco and alcohol, taxes on managed care, and taxes on hospitals. Given the rapid growth of Medicaid costs, it is obvious that such ideas are completely inadequate to solve the budget problem for more than about a year and would do nothing to address the more fundamental problems identified in this report. In particular, taxing the health care sector itself would only serve to make the problem worse, as it would reduce the supply of health care available for New Mexico citizens.

Moreover, higher taxes damage the New Mexican economy. Taxes need to be lowered, not raised. The Rio Grande Foundation has documented this relationship between the state’s high taxes and its poor economic performance in previous studies. See our web page, <http://www.riograndefoundation.org>, for further information and analysis.

²¹ *Albuquerque Journal*, October 24, 2002, page D3.

Because it would be so hurtful to the people of this state, we adamantly reject any proposal to raise taxes to cover growing Medicaid costs. Lowering taxes would substantially improve the wellbeing of New Mexicans, reducing their need for Medicaid.

A Superior Solution: Depend on Markets and Individual Choice:

All of the options discussed so far assume the continuation of Medicaid as we know it, but with a few wrinkles in its regulations and payment schedule. A few other states are beginning to take a more farsighted approach that we believe holds the most long term promise.

Medicaid takes the following approach: Let eligible people have all the medical care they want at no cost to them, with the government paying the bill. The result is that people not only use more medical care than they would if they had to pay for it, but that they also get more medical insurance than they would buy on their own, even if they were paid in cash an amount equal to the government's costs. The other result is that the government takes on an administrative task that experience has shown to be too often beyond the competence of government.

The Bush administration has taken steps to encourage Medicaid waivers, whereby states can experiment with different approaches. New Mexico may be able to obtain waivers to try innovative, market approaches.

One approach to get the government into the background would be to install a system of refundable tax credits and/or vouchers for medical insurance. This would cure many of the ills of the current Medicaid system, as the vast majority of people would choose a health care policy with high deductibles and copayments.

This approach is known as a "defined contribution plan." In essence the Medicaid beneficiary uses money provided by the government to purchase a health insurance plan of his choosing. It could be a high deductible or low deductible policy. It could entail high or low co-pays. It could cover some routine kinds of care like eye-glasses if the Medicaid beneficiary chooses to bear that cost. The important point is that the Medicaid beneficiary would be choosing the plan she thinks is best for her, spending her money as a careful shopper in the way she thinks will do her and her family the most good.

The following table illustrates how a **defined contribution approach** for a family of four explicitly recognizes the trade-offs between the amount of money provided for Medicaid insurance and the implicit tax rate (the disincentive to work and earn income). Notice that the truly needy get the most help and that the help is phased out at an implicit tax rate of 15% as income increases.

Family Income	Money for Defined Contribution Package	Implicit Tax Rate
	\$ 6,600	
\$ 2,000	\$ 6,300	15%
\$ 4,000	\$ 6,000	15%
\$ 6,000	\$ 5,700	15%
\$ 8,000	\$ 5,400	15%
\$ 10,000	\$ 5,100	15%
\$ 12,000	\$ 4,800	15%
\$ 14,000	\$ 4,500	15%
\$ 16,000	\$ 4,200	15%
\$ 18,000	\$ 3,900	15%
\$ 20,000	\$ 3,600	15%
\$ 22,000	\$ 3,300	15%
\$ 24,000	\$ 3,000	15%
\$ 26,000	\$ 2,700	15%
\$ 28,000	\$ 2,400	15%
\$ 30,000	\$ 2,100	15%
\$ 32,000	\$ 1,800	15%
\$ 34,000	\$ 1,500	15%
\$ 36,000	\$ 1,200	15%
\$ 38,000	\$ 900	15%
\$ 40,000	\$ 600	15%
\$ 42,000	\$ 300	15%
\$ 44,000	\$ -	15%

While this trade-off seems eminently fair to us, we can see political difficulties in implementing such a plan – those with higher incomes have a more effective voice and will certainly plead the continued virtue of providing them with the “free” Lexus of health care! The legislature may be able to counter this difficulty by mobilizing the group with income levels in the high 40s/low 50s: why should they have to be content with purchasing a used Ford Taurus with their own money when they could make a little less income and get a brand-new “free” Lexus from the government!?

In summary, we have chosen a particular defined contribution plan to illustrate the superiority of that approach compared to the existing situation. While we think the subsidy chosen combined with its rate of phase out is pretty sound, the important point is that policy makers need to address the trade-offs involved. Even the mandated benefit approach involves choices of an implicit subsidy combined with a phase-out rate, and those choices determine the effectiveness and efficiency of Medicaid policy. Unfortunately, these choices are obscured by the complexity of Medicaid mandates and eligibility criteria. Moreover, all welfare programs are similarly affected by their subsidies and rates of phase out. Enlightened public policy needs to cope with the trade-offs involved. Indeed

Medicaid policy should not be made in a vacuum; it needs to be considered in combination with other welfare programs and tax policy.

Benefits of Choice under Defined Contribution

Now we can summarize the benefits of moving to a defined contribution policy for Medicaid along with some additional considerations and caveats.

Medicaid Patients

Medicaid patients will have much more latitude in choosing providers and treatments. Many will choose insurance policies with high deductibles. That means that most of their expenses will be with money used as if it were their own. They will shop as careful consumers of the quality care they want at the price they can afford. Overall this approach will:

- Improve the situation of the truly needy
- Improve incentives to engage in productive behavior
- Contain costs
- Improve incentives to engage in healthy life styles

The large deductibles in the spending accounts must be carefully controlled to keep recipients from gaming the system for cash. For example, the family might purchase a catastrophic policy for \$2,100 with its subsidy of \$5,100. That leaves it with a deductible of \$3,000 that it can spend for health care as it sees fit. What happens if it only spends \$600 during the year, leaving \$2,400? It is important that the family has an incentive to treat the \$2,400 as theirs. One way to do this is to roll over remaining funds year-to-year, so that their health care account builds over time. Policy could allow recipients access to the money some time after they have risen beyond Medicaid eligibility thresholds – say five years.

Health Care Providers

Health care providers will have greater incentives to give patients what they want. Competition will tend to discipline providers regarding price and quality of medical services – the consumer is sovereign. Providers will work with consumers to evaluate their trade-offs. Providers will tend to innovate in response to consumer wishes compared to the top down, mandated benefits approach. Providers will enjoy providing medical services more and coping with Medicaid paperwork less. Providers will also enjoy getting prompt payment from the large deductibles that patients have available to spend.

Government Budgets

Crowd out will be a thing of the past as health care markets replace Medicaid. Competition will discipline consumers and providers. Budgets will be reduced by at least 20 to 30 percent relative to the mandated benefits approach and probably a lot more²². This is the long-term kind of fix that New Mexico needs.

Policy makers and taxpayers will be able to see at a glance the trade-offs between the amount of help provided and its rate of phase out as income increases. No longer will Medicaid budgets and policy be such a mystery.

The General Public

The general public will benefit from the spillover effect of improved markets for health care. They should enjoy simpler, less costly insurance options.

How to Implement Defined Contribution Reform in New Mexico

The Bush Administration seeks innovative, market approaches to Medicaid. To that end it seeks requests from states for waivers from Medicaid mandates. We recommend that New Mexico seek such a waiver to implement a defined contribution plan like the one suggested above. Much work needs to be done to evaluate the subsidy requirements and phase-out rates for each Medicaid eligibility category. And those subsidies and phase-out rates should be considered in the context of overall welfare programs and tax policy.

²² Actually budget impacts may be *much more favorable* since they do not include the reduced subsidy to higher income groups and the reduction in crowd out. The 20 percent figure comes From Willard G. Manning *et al.* June 1987, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, p. 251. 31 percent was the actual estimation in Martin Feldstein and Jonathan Gruber, Sept. 1994, "a Major Risk Approach to Health Insurance Reform," Working Paper No. 4825, National Bureau of Economic Research, Cambridge, MA.

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