GALEN INSTITUTE
A not-for-profit health and tax policy research organization

November 8, 2017

Health Reform: Helping the States Help the Poor

By Grace-Marie Turner

Many Catholics, especially Catholic leaders, have been conflicted over bills that have been presented to "repeal and replace" the Affordable Care Act: They strenuously object to the ACA's affront to religious liberty yet they know it offers access to health insurance for millions, including those who have been left behind in our bifurcated system.

Bishop Frank J. Dewane of Venice, Florida, Chairman of the U.S. Bishops' Committee on Domestic Justice and Human Development, issued a statement in June about a discussion draft of health reform legislation that was then before the Senate, the Better Care Reconciliation Act. He praised its life protections: "The Bishops value language in the legislation recognizing that abortion is not health care by attempting to prohibit the use of taxpayer funds to pay for abortion or plans that cover it. While questions remain about the provisions and whether they will remain in the final bill, if retained and effective this would correct a flaw in the Affordable Care Act by fully applying the longstanding and widely-supported Hyde amendment protections. Full Hyde protections are essential and must be included in the final bill."

The leadership in the Senate, the House, and the White House know that any future health reform legislation must contain these strong life protections.

But in his statement, Bishop Dewane criticized the Senate bill for its "detrimental impact on the poor and vulnerable." In particular, he cited the proposal for "a 'per-capita cap' on Medicaid funding, and [that] connects yearly increases to formulas that would provide even less to those in need than the House bill. These changes will wreak havoc on low-income families and struggling communities, and must not be supported."

He cited as the greatest concern spending reductions in Medicaid, the program that is jointly funded by the federal and state governments to finance health care for the poor, blind, disabled, frail elderly, pregnant women and children, and, under the ACA, also to single, non-disabled adults.

Several bills considered by the Congress this year would reduce federal spending for Medicaid over the next ten years. But the formula is a relatively small reduction in the *rate of increase* in spending from current law. Federal Medicaid actuaries estimated that under the bill that passed the House in May, Medicaid would spend an average of $8,673 a year on traditional Medicaid recipients next year and $11,948 in 2026. That is how a "reduction" in spending looks in Washington.

A subsequent bill offered by Sens. Bill Cassidy of Louisiana and Lindsey Graham of South Carolina sought to equalize Medicaid spending across the states over time rather than having a few

states receive a very disproportionate share of federal dollars, as they do today.

The Graham-Cassidy bill took a different approach than health reform bills considered earlier this year by the House and Senate. It is built around the undeniable truth that the federal government is completely out of its element in trying to micromanage something as vast, complex, and personal as the U.S. health sector. Their bill would devolve authority and additional resources to the states to oversee health insurance and health spending programs in their states.

The bill would leave most of the taxes in the Affordable Care Act in place and would distribute the money to the states, also allowing more waivers to the states so they could tailor health programs to better meet the needs of their residents. The Graham-Cassidy bill also has very strong life protections, developed under the guidance of former Sen. Rick Santorum who is working with them in developing the bill.

While the Graham-Cassidy bill did not come before the Senate for a vote, the concept of Federalism upon which it is based is likely to be the basis for new legislation the Congress is expected to consider next year when it returns to this issue. Federalism is basically subsidiarity in public policy.

The bill would give states much more flexibility to manage their Medicaid and health care exchange programs. States would be given new flexibility to deliver better services, target services to those most in need, and make the programs more responsive and efficient. In the current Washington-centric system, states must fight through Washington's regulatory thicket to make even minor changes to their health care programs. This keeps them from being able to make changes and adjustments to better fit spending and care delivery to the needs of their citizens.

For example, states would be able to combine Medicaid, CHIP, and exchange dollars to help people obtain more seamless coverage for themselves and their families rather than being bounced in and out of government programs when their income changes even by small amounts. This would provide the opportunity for people and families to have more stable coverage and for states to provide more options and opportunities for residents in the individual and small group markets to get more affordable policies.

Many single adults on Medicaid would be able to move into private coverage, freeing vital Medicaid resources to provide better care and better access to care for poorer, more vulnerable citizens who rely on the program.

Assessing the facts will help us find the right path.

There currently are more than 72 million Americans on Medicaid. It is the fastest growing health program in the country. The ACA dramatically expanded access to the program to cover, for the first time, able-bodied, childless adults above the poverty line. The health overhaul law provided a big incentive for states to enroll these individuals: The federal government picked up 100% of the costs at first, dropping to 90% in 2020 and beyond.

Because of Obamacare, the federal government pays states much more to enroll these individuals than it does to cover children, blind and disabled adults, pregnant women, and the frail elderly. The federal government matches only 50% to 75% of the costs of these traditional Medicaid recipients.

Thirty-one states and the District of Columbia expanded Medicaid, and most have expended major efforts to enroll these newly-eligible recipients while often neglecting those who are much more in need. Unfortunately, this means many needy and vulnerable Medicaid recipients

now are on waiting lists for services, and they must compete with millions of new Medicaid enrollees for access to the same number of physicians. The National Center for Health Statistics at the Centers for Disease Control found that primary care doctors are 73% more likely to reject Medicaid patients relative to those who are privately insured, and specialists were 63% more likely to reject them.

Medicaid is expanding beyond the capacity of the medical profession to provide services and for states to pay. Ohio expanded Medicaid under ObamaCare and saw its rolls increase beyond the expected 447,000 to 725,000, causing a financial crisis in the state—even with the generous federal matching payment. As a result, the state has had to cut back elsewhere. Now, nearly 60,000 disabled citizens in Ohio are waiting to receive supplemental state services while hundreds of thousands of able-bodied adults jumped ahead of them to get full Medicare coverage.

These vulnerable citizens should not be forced to wait for Medicaid services while their states aggressively work to enroll these new recipients, who should and would be given other options for coverage.

With the new flexibility the states would have, they could give residents the option of having private plans many would prefer, with better access to physicians and coordinated care than Medicaid allows today. And that would allow Medicaid to focus more on providing better care for those citizens who have no other options for care.

We must improve this program, but, because the federal government is so deeply involved in micromanaging it, states have little opportunity to develop creative, local solutions. The Congress wants to change that.

Governors are anxious to help their citizens get better access to care with creative new health care delivery and financing options. Some examples:

- Indiana launched its popular Healthy Indiana program a decade ago, giving lower-income uninsured citizens the option of insurance that works more like private coverage: If they contribute a modest amount to an account to fund their routine care, they will have the assurance of 100% coverage for larger medical bills.

- Rhode Island received a Medicaid block grant from the Bush administration in 2008 that is similar to the funding plan in Graham-Cassidy. Rhode Island reduced its Medicaid expenditures without cutting recipients from its rolls. The flexibility of the block grant meant it didn't have to play mother-may-I with Washington for every program change and was therefore able to target resources more efficiently to recipients. The program has succeeded under both Republican and Democratic governors in delivering better, more targeted care to its Medicaid populations.

In a recent speech at the Convocation of Catholic Leaders in Orlando, FL, Bishop James Conley said that "any health reform must be economically realistic and financially sustainable. We can't help anyone, including ourselves, if we are insolvent. If we commit ourselves to health services, then we need to have the will and the ability to really pay for them. That's a moral issue, not simply a practical one."

Many states find that Medicaid is consuming so much of their state budgets that they are forced to cut spending on education, transportation, public safety, and other vital public services their citizens rely on. Giving states more control over their Medicaid spending so they can stretch Medicaid dollars further will allow the states to balance these federal services without the federal government tipping the scales toward spending on health care—which is often encumbered by wasteful bureaucratic restrictions.

This is true subsidiarity—moving decisions closest to those affected by them.

Finally, many in the faith community were alarmed about reports about the number of people who would not have health coverage under the Senate bill (22 million) and the House bill (23 million), according to the Congressional Budget Office. Health and tax policy expert Ryan Ellis explained the problems with the CBO analysis in detail in a recent post for Catholic Vote. Doug Badger from the Galen Institute says that CBO isn't saying that these citizens will lose coverage because the House or Senate bills aren't spending enough: No. It says people would voluntarily drop coverage because the IRS would no longer be forcing them to buy coverage because the individual mandate would no longer be in effect.

The Graham-Cassidy bill would repeal the fines collected for those who don't comply with the individual mandate, basically voiding the widely unpopular provision that forces all Americans to have health insurance that meets government requirements. CBO says that next year alone, repealing the tax on the uninsured would induce 6 million people to cancel their individual insurance policies, 2 million to drop their job-based coverage, and 5 million others to abandon Medicaid, even though Medicaid is free of charge in most cases. The CBO's projections have been widely criticized, and the agency is in the process of reevaluating its estimates.

The bottom line: The majority of those losing coverage, according to the CBO, would voluntarily drop it, not be forced out of coverage. Instead, the Congress is working on legislation that would give states more power to approve better, more affordable health insurance policies that people would want to purchase, and they would allow states to shape Medicaid to take better care of their most vulnerable citizens.

Congress could return power to states and ultimately to individuals regarding health insurance decisions, while giving states greater incentives to care for the most vulnerable residents.

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