CHAPTER SIX

Reform #5: Overhaul Medicaid and Eliminate the Two-Tiered System for Poor Americans

Principal Features of Reform #5: Overhaul Medicaid and Eliminate the Two-Tiered System for Poor Americans

- Provide private insurance options for all Medicaid enrollees without need for special waivers
  - Permit all insurers, including all companies available on state and federal exchanges, to offer true high-deductible, LMCC plans (covering hospitalizations, outpatient visits, diagnostic tests, prescription drugs, and mental health) to the entire state population, including those eligible for Medicaid
  - Eliminate the requirement of special waivers for Medicaid enrollment into private insurance
- Establish and seed fund HSAs for all Medicaid enrollees
  - Open HSA automatically for every Medicaid enrollee and have limits and uses match other HSAs
  - Create new incentives for healthy behavior, which will save and protect growing financial assets
  - Ensure that seed funding goes directly into HSAs as part of federal contribution every year
  - Permit tax-free rollovers of all HSAs to surviving family members
- Change federal contribution to states for Medicaid to fixed amounts but with threshold-based incentives
  - Ensure that at least 50 percent of Medicaid enrollees are enrolled in LMCC plans
  - Ensure that at least 50 percent of Medicaid enrollees have at least partially funded HSAs

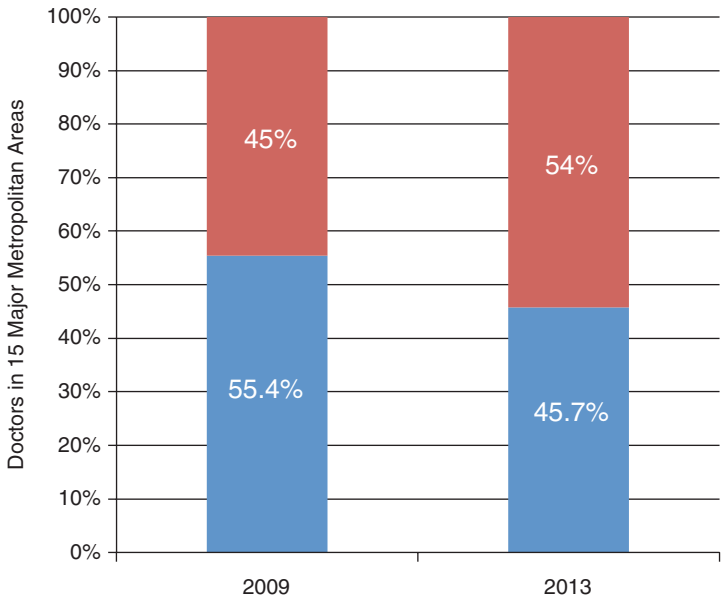
Medicaid is different from Medicare. Medicaid is generally a subsidy for the poor, paid by federal funds and state funds. Medicaid is intended to help provide access to good medical care and improved health for those who cannot afford it. Instead of providing a pathway to excellent health care for poor Americans, however, Obamacare's expansion of Medicaid continues and even exacerbates their second-class health care status and does so at a cost of $500 billion per year to taxpayers, a cost that rises to $890 billion in 2024.[1] As an alternative, a few states have taken the lead within the confines of the ACA via special waivers to facilitate a transition into private coverage with better access to medical care. Arkansas and Iowa have received approval to use the "private option" in which Medicaid provides premium assistance to purchase private plans in lieu of direct Medicaid coverage.[2] In Arkansas, about 85 percent of Medicaid beneficiaries are now eligible for the private option, and as of January 1, 2015, Iowa has used it as an option for enrollees with income between 100 percent and 133 percent of the federal poverty level. In addition, Michigan and Indiana have added HSA options for Medicaid beneficiaries, and Arkansas has begun the approval process. Although these Medicaid pilot projects are still burdened with a mandated set of benefits and other regulations under the ACA, these states' efforts are steps in the right direction.

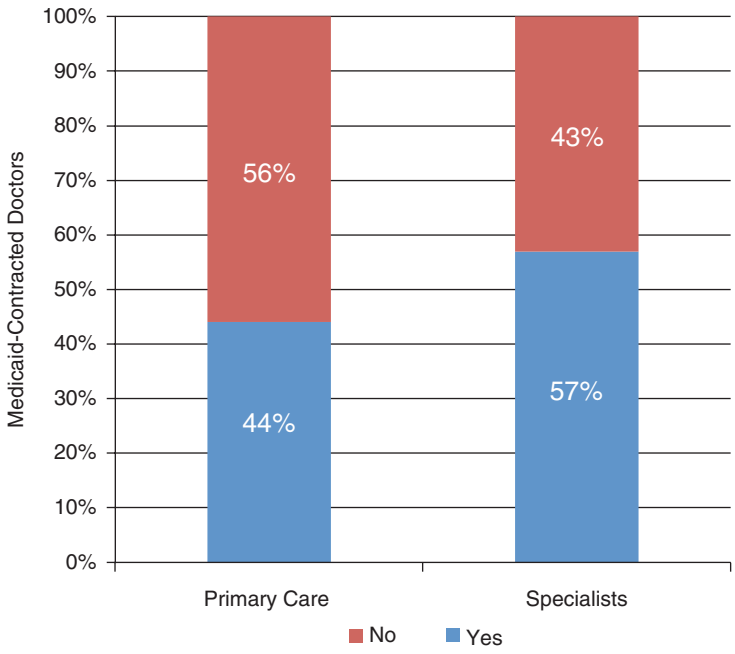
FIGURE 6.1. (*top, facing page*) Percentage of Doctors* Accepting New Medicaid Patients, 2009 vs. 2013 Overall, Fifteen US Major Metropolitan Areas. (*bottom, facing page*) Percentage of Medicaid-Contracted Providers Who Could Offer an Appointment to a New Medicaid Patient, by Type of Provider, 2014.

Most doctors do not accept Medicaid patients, and the proportion of doctors who accept new Medicaid patients has been decreasing. Even of the doctors already contracted by Medicaid and listed as accepting patients, a large percentage do not accept new Medicaid patients. Obamacare has massively expanded Medicaid enrollment, but most enrollees will not be able to find doctors who will accept them as patients.

Note: *Includes cardiology, dermatology, obstetrics and gynecology, orthopedics, and family practice.

Sources: (*top*): Merritt Hawkins, "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates, 2014 Annual Survey," http://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Surveys/mha2014waitsurvPDF.pdf 2014; (*bottom*): Department of Health and Human Services, "Access to Care: Provider Availability in Medicaid Managed Care" Report OEI-02-13-00670 (December 2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.


Doctors in 15 Major Metropolitan Areas
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
45%
55.4%
54%
45.7%
2009
2013


Medicaid-Contracted Doctors
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
56%
44%
43%
57%
Primary Care
Specialists
No
Yes

—-1
—0
—+1

The time is long overdue for a more fundamental overhaul of Medicaid, with more aggressive reforms to truly modernize it into a program with improved benefits and ultimately reduced costs. Traditional Medicaid is essentially sham insurance that most doctors do not even accept (Figure 6.1).

My plan transforms Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance instead of a parallel second-class system funneling low-income families into substandard traditional Medicaid coverage. The plan establishes and seed funds HSAs, a vital component of empowering enrollees with the same control and incentives as all other Americans while instilling incentives for good health. These reforms would change the purpose and culture of Medicaid agency offices from running special government-administered Medicaid plans to establishing HSAs and finding private health plans for Medicaid beneficiaries.

The new Medicaid will have several features. First, new Medicaid will include a LMCC private insurance option for all enrollees, without any need for special waivers. Second, new Medicaid will establish and seed fund HSAs for the program's low-income American enrollees, in turn creating growing assets and incentivizing healthy lifestyles to protect those assets. To ensure the availability of the same health care to Medicaid enrollees as is available to Americans outside the program, federal funding will be available only to states that offer these same private coverage options to the entire state population, including Medicaid-eligible and non-eligible families; moreover, that funding will be contingent on meeting certain enrollment thresholds for Medicaid enrollees into LMCC private coverage and funding into HSAs. Funds will be allocated via fixed dollar amounts to states, but directly toward individual HSAs or insurance premium payments rather than into inefficient state bureaucracies. Ultimately, traditional Medicaid coverage will be eliminated over decades as new enrollees move toward private plans with HSAs.

The new Medicaid will financially empower low-income Americans to (1) purchase affordable, private insurance identical to what any American citizen could buy; and (2) fund HSAs that provide control and choice and, just as important, build assets worth protecting. These incentive-based Medicaid reforms would move Medicaid enrollees to private coverage, with equal access to doctors, specialists, treatments, and medical technology as the general population, eliminating the two-tiered health system that Obamacare furthers. It would give control of the health care dollar to low-income families to empower value seeking and foster provider competition for that money. Medicaid HSAs would provide new incentives for lower-income families to seek good health through wellness programs and healthy behavior in order to save and protect their new, growing financial assets.