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MEDICAID COMMISSION RECOMMENDATIONS RAISE SERIOUS CONCERNS

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On November 8, the Medicaid commission created by the Administration last year released a "chairman's mark" setting forth broad recommendations designed to "promote Medicaid's long-term fiscal sustainability, while also emphasizing quality of care." The commission will consider these recommendations at its final meeting on November 16 and 17.

In general, the recommendations are framed so broadly that it is difficult to determine exactly what policy changes they would make. No cost estimates are provided. Nevertheless, a number of the recommendations raise serious concerns, especially for vulnerable groups such as low-income seniors or people with disabilities. (The commission was hand-picked by Department of Health and Human Services Secretary Leavitt, and only a handful of its 15 voting members represent the specific interests of low-income children, families, or senior citizens.) The most significant of these concerns are outlined below.

- **Allowing states to place elderly and disabled beneficiaries in managed care.** The most troubling recommendation concerns the roughly 7.5 million Medicaid beneficiaries who are either elderly or disabled and thus are eligible for Medicare as well as Medicaid. The chairman's mark would permit states to enroll these "dual eligibles" in managed-care plans.

  Currently, most dual eligibles receive Medicare and Medicaid services through a traditional "fee-for-service" arrangement, in which health-care providers bill the government for the cost of the services they provide to beneficiaries. Under a managed-care arrangement, in contrast, private firms receive a set amount per beneficiary from the government to provide health care. This gives them an incentive to keep costs as low as possible — including, potentially, by skimping on beneficiaries' care.

  Managed care for dual eligibles could theoretically improve coordination between Medicare and Medicaid and reduce costs, and a few pilot projects in this area appear promising. But as a recent *Wall Street Journal* article on Medicaid managed care* suggests, allowing states to simply enroll dual eligibles in managed care would create real risks. As the chairman's mark notes, dual eligibles have lower incomes and more impairments than regular Medicare beneficiaries and are more likely to live in nursing homes. Yet the recommendation specifies no minimum federal standards to protect dual eligibles from substandard health plans. While these individuals

* "In Medicaid, Private HMOs Take a Big, and Profitable, Role," November 15, 2006.

would be able to "opt out" of managed care if dissatisfied, the obvious vulnerability of this population — fully one-third of dual eligibles have mental impairments or disorders — makes it unlikely that many would be able to understand, let alone exercise, this option.

- **Giving states far-reaching and open-ended flexibility to change Medicaid benefits and eligibility.** The chairman's mark would appear to allow states to provide different benefit packages to different groups of beneficiaries, with virtually no federal protections. States could, for example, decide that some beneficiaries would no longer be eligible for inpatient care or doctor visits. States also could set their financial eligibility levels below the minimum levels that currently guarantee coverage for certain groups such as poor children and pregnant women.

  These recommendations appear to go far beyond what states can do under the Deficit Reduction Act enacted this February, which allows states to provide scaled-back benefits for some children and parents. Under the commission proposal, states could provide scaled-back benefits to certain groups of beneficiaries based on their health condition, their age, or where they live, without any apparent exemption for elderly people or people with disabilities.

  The recommendations also appear to go far beyond what states have been allowed to do through waivers of federal Medicaid law. Through waivers, states have been allowed to provide limited benefit packages (such as packages that do not include hospital care) for groups that are ineligible for Medicaid under usual program rules, such as childless adults. The chairman's mark apparently would allow a state to provide this same limited benefit to groups that *are* eligible for full Medicaid coverage, such as parents, children, and the elderly or seriously disabled. States apparently could simply provide beneficiaries with vouchers to purchase coverage on their own in the private market, with no federal standards as to the benefits that the plans would have to cover, no limits on the out-of-pocket costs that poor beneficiaries would have to pay, and no guarantees of access to affordable plans in the generally unregulated private market.

- **Creating new federal tax subsidies for the purchase of private long-term care insurance.** These subsidies, which include a tax deduction for the purchase of long-term care coverage, would be unlikely to significantly increase the number of people with such coverage because they would do little to help low- and moderate-income people purchase it. The bulk of the benefits of these subsidies would go to high-income taxpayers, who are the people most likely either to have long-term care insurance already or to be able to pay any future long-term costs directly.

  Moreover, the chairman's mark does not include necessary insurance-market reforms to make long-term care insurance more accessible or affordable. In the absence of significant reforms, large numbers of individuals likely would be shut out of the market for individual long-term care policies entirely, because companies selling such insurance in the individual market generally can vary the premiums they charge based on age and medical history. Indeed, companies routinely deny coverage to those who are at greater risk of needing costly long-term care. Up to 23 percent of applicants for long-term care insurance at age 65 are rejected outright, according to a Commonwealth Fund study.

  At the same time, the proposed tax subsidies would add significantly to the federal budget deficit. Since they are unlikely to reduce Medicaid costs substantially, their net fiscal effect would almost certainly be to worsen the nation's long-term fiscal problems, which in turn could ultimately add to pressure for deeper reductions in health-care programs such as Medicaid.