

THE ECONOMICS
OF MEDICAID
Assessing the Costs and
Consequences

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CHAPTER 7: REFORMING MEDICAID

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The Medicaid program today bears little resemblance to the program Congress thought it was creating nearly a half century ago. The priority for the drafters of the 1965 amendments to the Social Security Act was creating health insurance for the elderly—Medicare. Medicaid received far less attention.¹ The drafters thought they were providing federal structure and uniformity, as well as some funding, for the many state programs long in existence that were already providing “indigent care.” The congressional authors of the legislation were not aware that what they were setting in motion was a program that would become the largest entitlement—by enrollment—in the United States. Today, Medicaid costs federal and state taxpayers \$440 billion annually and serves about 70 million people.²

Medicaid’s financing and programmatic problems are rooted in its original legislative design. As a shared federal–state program, it is financed partly by the federal government and partly by the state, resulting in split political accountability. State officials often blame the federal government for imposing costly mandates in Medicaid, even as federal officials and agencies increasingly blame the states for

using the program as a means of tapping federal taxpayers to solve their budgetary problems.

The method by which Medicaid's costs are assigned to the federal and state governments—a state-specific federal match rate—is a primary source of the program's perverse incentives. On average, the federal matching rate is 57 percent of state Medicaid costs, meaning the federal government covers \$0.57 of every \$1.00 in state-initiated Medicaid spending. Because there is no upper limit on federal Medicaid funding, states can reduce their budgetary costs if they are able to move programs traditionally financed with state-only funds under the Medicaid programmatic umbrella, thus drawing partial federal support. Not surprisingly, this has been a common practice among the states for many years.³ (For more on states' budgetary incentives, see chapters 1 and 4, pages 9 and 65.)

Further, the Medicaid matching formula undermines the incentive for spending discipline at the state level. The shared financing of Medicaid means that states can initiate new spending in Medicaid and have it partially financed by federal taxpayers; but the flip side is that state-initiated Medicaid spending cuts must also be shared with federal taxpayers. So, for instance, in a state where the federal government is financing 60 percent of Medicaid spending, the governor and state legislators face the unattractive prospect of keeping only \$1 in savings for every \$2.50 in Medicaid spending cuts they can identify and implement. The other \$1.50 in savings is returned to the federal treasury. This kind of formula is a major disincentive to cost-cutting by state politicians.

Widespread recognition of these and other shortcomings in Medicaid have led to near continuous calls to reform the program, both at the federal and state levels of government. To date, these reform efforts have not yielded fundamental transformation of the program.

THE WAIVER OPTION

Medicaid rests on an uneasy federal–state relationship. The federal government finances more than half of the program, but the states initiate the spending. Not surprisingly, because federal taxpayers are on the hook for a substantial (and unlimited) portion of the costs, the federal government has not hesitated to steadily impose more and more federal controls over the program’s basic operations, through legislative as well as regulatory changes. These changes have mainly come in the form of new “mandates”—requirements that compel states to operate their Medicaid programs in conformance with an ever-expanding list of federal rules. These mandates affect everything from what states must provide in terms of covered services, to minimum payments to providers, to the categories of beneficiaries that must be made eligible for Medicaid coverage. For instance, from the beginning, the Medicaid statute required certain kinds of preventive services be provided to eligible children, but the definition of what is required was substantially broadened in legislation enacted in 1989.⁴ Every state must conform to that one national rule.

The impulse for the growing federal role in the program is, of course, rooted in part in the expectation that whoever is paying the bills (or the biggest part of them) should have a say in how the money is spent. But probably even more important has been the straightforward impulse to expand benefits and services to low-income populations. That has been a motivation for politicians in both parties.

For their part, the states have often resisted the proposals for new mandates and required coverage expansions considered by Congress and the Department of Health and Human Services (HHS)—but many expansions have occurred nonetheless.⁵ The desire to expand Medicaid’s reach to more and more people, and to cover more and more services, has proven to be far more powerful than any hesitancy about violating the terms of the original understanding of Medicaid, which was that the federal government would provide the overall structure for the program, but the states would have the biggest say in who is entitled and to what benefits.

The tension that the steady increase of federal control over Medicaid has created in the relationship with the states has manifested itself in several ways, but most especially in the rapid increase in state-initiated waiver requests.

The Social Security Act comprises the set of laws that addresses the Social Security program as well as Medicare and Medicaid. In Section 1115 of that act, Congress delegated to HHS the authority to waive certain requirements under the act in order to allow demonstrations of new approaches to implementing social welfare programs, including Medicaid. In addition, the Medicaid law itself includes waiver authority, allowing states to apply to HHS to utilize more managed care approaches to delivering Medicaid services (and thus exclude some doctors and hospitals from the Medicaid network of providers). States can also seek waivers to use Medicaid funds to pay for home- and community-based long-term care services instead of only using Medicaid to pay for nursing home care.

The use of waivers to run state Medicaid programs has become widespread. Indeed, anytime a state decides to pursue large-scale changes to how they run Medicaid, it is the norm, not the exception, to embed those changes in the context of a waiver request to the federal government. According to the database that HHS has made available online, 381 current waiver programs of all types have been approved by HHS and are in operation in the states, of which 41 are existing Section 1115 waivers.⁶ Section 1115 waivers give the secretary of HHS the authority to initiate “experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches.”⁷ Approximately 24 waiver requests are now pending at HHS.⁸

The statute intends that the federal government and the states will use waivers to test new concepts for a period of years, followed by an evaluation. If a test falls short of expectations, the waiver would be

expected to be discontinued. Similarly, successes would presumably influence national policy making for the other states.

The reality is very different. States have used waivers not so much to test new ideas, but to manage their programs outside of the constraints of some statutory provisions. In some notable cases, states have used Section 1115 waivers to pursue changes that constitute fundamental reform of how Medicaid operates or how Medicaid fits into the broader health system. Three state-initiated waivers from the past several years are noteworthy in this regard and provide good examples of the creative use of the Section 1115 waiver authority.

Indiana requested a waiver to allow persons just above the normal Medicaid income eligibility levels to enroll in a special insurance program featuring the use of health savings account (HSA)-style spending arrangement. The idea was to give these mainly uninsured residents of the state an insurance plan with out-of-pocket financial protection, and also a personally owned spending account to cover the cost of services below the relatively high (for Medicaid) insurance deductible. Indiana's governor at the time, Republican Mitch Daniels, pushed for the waiver on the grounds that it would expand coverage to many thousands of the uninsured in the state by using an approach that would promote consumer-directed health care and cost-conscious consumption of services.⁹ Medicaid funding was used both to subsidize the higher deductible insurance and to place funds in the HSA accounts for use by the enrollees. Indiana's original waiver was approved in 2007.

By all accounts, the Indiana experiment in HSAs worked very well for state residents. Enrollment exceeded 45,000 in just the first two years of the program, and the cost and health experience were very positive.¹⁰ According to an evaluation conducted by Mathematica Policy Research, the low-income participants in the Indiana initiative found the HSA approach attractive, with large percentages making contributions to their accounts to build assets for future health needs. Nonetheless, Indiana has been forced to engage in a protracted negotiation with HHS to get the waiver extended. In early September

2013, the Centers for Medicare and Medicaid Services (CMS) finally granted a one-year extension for the Indiana Medicaid waiver program.¹¹ And yet, despite the one-year reprieve, the long-term future for the program remains very much uncertain.

In Rhode Island in 2009, then-governor Donald Carcieri, a Republican, proposed to fundamentally transform the Medicaid program in the state by converting the federal contribution to the state program into a global cap on the program. Many viewed this proposal as a state-initiated version of a federal block grant. Instead of paying for a fixed percentage of Rhode Island's Medicaid costs, Governor Carcieri proposed that the federal government provide to the state a fixed total amount of federal funding regardless of the state's spending experience. In return for giving the federal government budgetary certainty, the state asked for substantial new flexibility to manage the benefits and populations covered by the program without regard to many federal rules. The administration of President George W. Bush approved the waiver in early 2009.

The Rhode Island waiver provoked strong negative reaction from those who thought it gave Rhode Island too much authority to unilaterally manage the program.¹² Supporters championed the proposal as a test of the Medicaid block grant concept. Early evaluations of the program showed that it largely met the expectations of Rhode Island officials. According to an independent assessment, the flexibility Rhode Island gained under the waiver allowed the state to generate "significant savings," including \$36 million over three years in reduced nursing home costs.¹³

In Massachusetts, an entirely different approach to reform was pursued by then-governor Mitt Romney in 2006. He proposed a waiver that would allow the state of Massachusetts to move federal funding for what are known as disproportionate share hospitals (DSH) into a new subsidized insurance scheme for persons not eligible for Medicaid. It was well known at the time that Massachusetts was in danger of losing the federal DSH funding entirely because of the illegitimate mechanism used to pay for the state's portion of the

cost. To prevent the loss of funding, Governor Romney, a Republican, worked with the state's Democratic legislature to propose a waiver that eventually became the model for President Obama's national reform legislation. In addition to moving the federal DSH funding into an insurance subsidy program, Massachusetts enacted an individual mandate on state residents, thus requiring everyone in the state to secure government-approved health coverage. It also created the "Connector" through which some state residents would use their new state subsidy for health insurance to purchase coverage from among competing private insurance plans.

The Massachusetts Medicaid waiver of 2006 was the most consequential waiver ever approved by the federal government. The Obama administration has argued forcefully that its adoption—on a bipartisan basis—by Massachusetts state politicians should have led Republicans at the national level to embrace the Patient Protection and Affordable Care Act (ACA),¹⁴ which shared some common elements with the Massachusetts program. But many in the GOP countered that the national law has given far more sweeping powers to the federal government than were handed to the Massachusetts state government under the 2006 waiver. Moreover, it is a very different matter to enact a state program from which other states can differ than to enact one national program that all states must adopt. Even so, it is undeniable that the approval of the Massachusetts waiver was an important step along the way to enactment of the sweeping national legislation.¹⁵

BUDGET NEUTRALITY AND THE WAIVER NEGOTIATION PROCESS

The federal government has approved scores of waiver requests for the states over the past four decades, but some have not been approved and more still have only been approved after a lengthy and oftentimes contentious negotiation between federal and state officials over the content of the waiver request.¹⁶

To some extent, ideology has played a role in the attitude of various administrations toward state Medicaid waiver requests. Republican administrations have tended to look favorably on requests to use more private insurance options to cover the Medicaid population. Democratic administrations have favored approaches that bring into Medicaid larger numbers of low-income residents.

But by far the most important consideration in any significant waiver request is the money. More specifically, the waiver requests from the states are assessed to determine whether or not they are budget neutral, meaning they are assessed to determine whether the federal government would pay more to the state under the waiver than it would without the waiver. Not surprisingly, this is the source of frequent disagreements between the states and the federal government.

The concept of budget neutrality in Medicaid waiver assessments dates back to the early 1980s. Prior to that time, HHS could approve state Medicaid requests under Section 1115 of the Social Security Act without regard to the waivers' impact on federal spending. The statute never mentions budget neutrality as a requirement for federal approval of the demonstration programs.

As HHS approved more and more requests by the states to waive certain Medicaid statutory provisions, the White House Office of Management and Budget (OMB) became concerned that the state programs being approved by HHS were actually costing the federal government substantially more than the regular Medicaid program. In 1983, early in the Reagan administration, OMB and HHS came to an agreement that all future Section 1115 waivers must be budget neutral to the federal government over the life of the demonstration.¹⁷ This agreement also gave OMB the authority to reject demonstration requests from the states that did not meet the test of neutrality. Since that time, OMB has played a central role in virtually all federal–state negotiations over significant waiver requests.

The budget neutrality test implies that the administration can apply an objective measure of financial rigor to assess the merits of state waiver requests. Unfortunately, the reality is that assessing budget

neutrality entails far more subjective judgments than any of the participants would care to admit.

The problem begins with the fact that the federal government does not maintain a 50-state baseline of Medicaid costs.¹⁸ The actuaries employed by CMS create a federal Medicaid baseline at least twice a year, with projections going out 10 years. But that baseline reflects aggregate federal Medicaid expenditures, not state-by-state spending. So, when a significant waiver request is made by a state, the actuaries have to construct a special state-only baseline estimate.

There are no definitive rules for doing this. For instance, what is the future growth rate of Medicaid expenditures in a given state? Is it the same as the assumed national trend rate? What if the state has had slower growth in recent years, or a changing demographic profile? Should that be factored into the assessment? And what about state claims that the waiver program will operate more efficiently than the existing program, or improve the health status of the served population and thus lower future costs? Is there validity to those claims? These are the typical questions at the heart of the federal–state negotiations over waivers.

And when there is so much room for judgment involved in assessing what is or is not budget neutral, the decision to approve or disapprove a waiver is inevitably moved from the civil service level to the political level. Thus, the boundaries of objective budgetary assessment are moved into the realm of more ambiguous political negotiation. With so much money at stake, states become heavily invested in the process. They lobby HHS and the White House vigorously; they make calls to the president’s political advisors; Congressional delegations become involved. The result is that the waiver approval process is a high-stakes political affair that has the feel of a legislative negotiation rather than consideration based on objective measures of a temporary test of a new idea, as the statute warrants.

It follows, too, that this kind of process leads to strong suspicions that the politically connected get the best deals. States with strong political connections to the White House are assumed to receive more

favorable judgments on how to calculate the state-specific Medicaid spending baseline, and thus provide more funding to those states under their waiver requests. This widespread perception of favoritism only further incents states to treat the entire endeavor as a highly politicized process, which means hiring a team of expensive lobbyists and using pressure from elected lawmakers from the state to pressure the administration to grant the waiver request.

The subjectivity of the Medicaid waiver approval process raises questions of fundamental fairness. Why should taxpayers in one state receive more favorable treatment than those in another state based on an idiosyncratic waiver approval process?

For this and other reasons, a better approach to fundamental Medicaid reform can be found in proposals to remake the program through federal legislation.

STATUTORY REFORM OPTIONS AT THE FEDERAL LEVEL

An effective Medicaid reform at the federal level would, first and foremost, address the fundamental flaw in Medicaid's current design: the matching formula used to establish the federal-state split on Medicaid costs. As stated previously, this approach to financing Medicaid undermines spending discipline and causes budgetary problems for the federal government as well as the states.

One approach to reform would be to convert the federal contribution to the states into a fixed federal block grant that would not be altered based on additional state spending. The idea would be to provide budgetary certainty to the federal government and the states and to provide strong incentives to the states to manage the federal funding prudently. Under a block grant, cost overruns at the state level would be financed entirely by state taxpayers, not the federal government. Conversely, the federal contribution to a state would not decrease if the state found ways to cut Medicaid costs. All of the savings from rooting out waste and efficiency would accrue to state

taxpayers. This is how the state children's health insurance program has been structured since enactment in 1997.

The key issue in converting to a block grant is establishing the basis by which the federal government will make payments to the states. One option would be to examine historical Medicaid spending levels by the federal government in the various states over a preceding number of years, such as perhaps the three most recent years. The first year of the block grant could then be calculated as the average of federal Medicaid spending in the state per year during that period of time, inflated to the year in question by the national Medicaid spending growth rate.

Once the first year is settled, the question becomes how to inflate the federal Medicaid block grant amounts in future years. The indexing options include using the consumer price index (CPI), which historically is well below medical inflation, the growth rate of the national economy as measured by gross domestic product (GDP), or perhaps a measure of national or regional health spending growth. The decision on indexing is highly consequential because alternative approaches can result in large differences in federal spending over time. If the block grant is pursued in part to help ease the nation's severe, long-term budgetary challenges, then indexing the block grant amounts to something below the historical rate of growth for Medicaid can produce significant savings estimates, especially over the long term.

The budget resolution that passed the US House of Representatives in March 2013 assumed Medicaid was converted to a block grant and indexed to the CPI plus population growth in the states—a rate well below the historical rate of Medicaid spending inflation and well below what the Congressional Budget Office (CBO) assumes will occur absent a change in the legislation. Consequently, the House-passed budget's Medicaid plan would substantially reduce federal costs over the coming decade.¹⁹

Using historical rates of spending to establish the initial state block grant amounts locks into the block grant whatever irrational disparities in federal support exist today among the states. Some

proposals try to correct for large gaps between states by indexing the block grant amounts at differential rates. For instance, low-cost states might be indexed at a slightly higher-than-average rate, whereas high-cost states could be indexed at a rate below the national average. Proposals that make these kinds of adjustments necessarily generate a great deal of attention from the states and their representatives in Congress. The danger is that attempting to redistribute Medicaid funding among the states while also reforming the program could create so much political opposition that the reform fails. Consequently, reformers may instead want to enact a reform first that changes the nature of the federal–state financial relationship based on historical patterns of federal spending per state before addressing approaches to narrowing gaps among the states.

Opponents of the block grant concept argue that it will necessarily result in a reduction in services for vulnerable populations. But that is far from certain; the current program, with open-ended federal matching payments, provides strong incentives to the states to move as much spending as possible under the Medicaid umbrella, and little incentive to carefully scrutinize expenditures. With a block grant, the states would have strong incentives to eliminate waste without undermining coverage for those who truly need it.

In 1996, similar arguments were made about the block granting of welfare funding, with predictions that it would lead to significant hardship for the program's enrollees. What happened instead is that the states reviewed who was on the cash assistance program and quickly found that many of them were capable of entering the workforce and improving their household incomes from wages instead of government assistance. By 2000, the cash welfare rolls had fallen by about half even as the population in the bottom fifth of the income distribution experienced substantial gains in their real incomes.²⁰

Health coverage is more complicated than cash welfare, but there is every reason to expect that substantial inefficiency exists in Medicaid, and that a block grant would provide the incentive to find and eliminate it.

Still, concerns about the effect that a block grant might have on health services for the vulnerable has led to proposals that mitigate against some of the financial risks a block grant would entail. The most prominent example of such a proposal is per capita caps.

Under per capita caps, the federal government would establish for each state a per person payment based on the main eligibility categories in the Medicaid program: the elderly, the blind and disabled, nondisabled adults, and children. The federal government would then make payments to the states based on the number of Medicaid enrollees in each of these categories. The per capita payment would be based on historical spending rates for the various categories of beneficiaries in each state, and, again, would be indexed to a predetermined growth rate.²¹

Per capita caps in Medicaid would have the same advantages as a block grant in that the states would have strong incentives to use the federal funding wisely. The amount of the federal payment per person would be the same regardless of how much the state spent on each enrollee. The only difference with the block grant is that the states would not be at risk for increased enrollment in the program because the per capita payments would be made for all enrollees in the program, including those who might not have been expected to sign up and thus were excluded from the block grant formula. This could be important in times of slow economic growth or during a recession, when Medicaid enrollment typically surges.

Perhaps most important, per capita caps have enjoyed bipartisan support in the past. In 1995 and 1996, the Clinton administration proposed Medicaid per capita caps as part of a larger balanced budget plan. That proposal was explicitly endorsed by 46 Senate Democrats in a letter to the president in December 1995.²²

Both the block grant and per capita caps would remove from the program the distorted incentives that flow from today's matching rate approach to Medicaid financing. They would also free up the states to pursue reforms that, until now, have been difficult to implement in Medicaid because of federal concerns. Specifically, states that would

like to pursue more market-driven Medicaid reform could move directly to convert the program from what might be called a “defined benefit” model of insurance to one based on defined contributions. Instead of entitling beneficiaries to a set of services, states could give Medicaid participants a fixed level of support—a defined-contribution payment—and then allow the Medicaid beneficiaries to use that support to pick from among a number of competing insurance options. The Indiana approach of using the defined contributions to fund an HSA-like account could be part of the reform.

This approach to state-driven Medicaid reform would use competition and consumer choice to hold down costs instead of the unrealistically low payment rates that are now used by states to cut payments to doctors and hospitals. Nonelderly and disabled beneficiaries would be free to choose from among competing insurance options, which would create pressure on the insurance plans to provide better access to care than is provided under today’s Medicaid program. Under this approach, states would need to ensure the defined contribution was adequate to get reliable insurance, but it would also create pressure to hold down costs because the Medicaid participants could keep the savings from enrolling in lower-premium plans.

States could also pursue a defined-contribution approach for their elderly and disabled populations. The purpose would not be to finance insurance enrollment but to provide resources for the direct purchase of needed long-term support services. One approach would be to establish a maximum contribution based on a severely disabled person needing extensive support. Persons with lesser disabilities would get a fraction of the maximum amount commensurate with their needs. The recipients, and their families and caregivers, would then use the fixed level of support from Medicaid to secure services from a competing list of approved service providers. This approach would foster strong price competition and allow the recipients and their families to target their resources on their most significant needs.²³

A main objective of this type of reform for the elderly and disabled would be to reduce the use of expensive nursing home care

by improving the services available for those who remain in the community. However, some state residents will still require nursing home assistance. The cost of nursing home care could be provided outside of the defined-contribution context, with the state paying directly for those services, perhaps on contracts awarded to nursing homes with the higher-quality indicators and reasonable costs.

A federal move toward block grants or per capita caps would provide much greater budgetary control at the federal level. States could achieve a similar level of enhanced budgetary control by moving to a defined-contribution approach. Instead of unpredictable and open-ended benefit commitments, a state could provide fixed levels of support to program participants. Opponents will say this is an unfair shift of risk onto the program's participants. But a shift to defined-contribution payments would not result in reduced benefits if it brings about new levels of efficiency and productivity in the provision of services. Indeed, the whole point of such a reform is to foster competition and innovation that improve the quality of choices for the program's enrollees, not worsen them. And there is strong evidence from other market-driven models, like the Medicare drug benefit, that competition and choice will have exactly this effect on costs in Medicaid.²⁴

CONCLUSION

The Medicaid program is now a dominant part of American health care, but there has always been uneasiness about its design, dating all the way back to its enactment in 1965. Costs have grown so much that they threaten to push federal and state budgets past the breaking point. Although millions of Americans rely on Medicaid, there is much evidence that the program falls well short of the quality care that the population deserves.

The fundamental problem in Medicaid is that neither the federal government nor the states are fully in charge. Those who favor more centralized control over the nation's health system would like to resolve the tension in Medicaid by federalizing more and more

aspects of the program. That is why the health care law passed in 2010 required 100 percent federal funding for the first three years of the anticipated expansion. However, to date, less than half of the states have adopted the expansion, despite the promise of full, but temporary, federal financing. Based on the program's long history, many state governors and legislators are wary of setting in motion another long-term spending commitment within Medicaid that could burden future state taxpayers. Many state governors are also generally opposed to the 2010 health care law and would prefer to replace it with an approach that would elicit more bipartisan support.

Some states have pushed back against the steady federalization of Medicaid by pursuing various waiver approaches. But these waiver plans must still be approved by the federal government, which can be a large political exercise as well as a budget exercise, leaving states in the position of investing time and resources into securing Washington's approval of their plans.

A more permanent and stable approach to reform would fundamentally transform the nature of the federal–state relationship. Instead of micromanaging Medicaid, the federal government could provide a fixed level of support through Medicaid, with the states deciding how to spend those federal funds, as well as state resources, to help their low-income populations secure the health services they need. This kind of transformation of Medicaid could come with strong accountability provisions for the states, including measures of the health status of their vulnerable populations as well as estimates of insurance coverage rates. States would then have the freedom to manage the programs to improve the lives of their citizens, and could be held accountable by state voters.

NOTES

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2. Congressional Budget Office, "Medicaid Spending and Enrollment Detail for CBO's

- May 2013 Medicaid Baseline,” May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204_Medicaid.pdf.
3. For instance, in 2010, the state of Connecticut moved a state-funded and capped health insurance assistance program for low-income adults without children under Medicaid in order to secure federal matching funds. Ironically, the governor at the time, M. Jodi Rell, argued against the shift on the basis that it would be more difficult to control enrollment once the program became part of a broader Medicaid entitlement. See Keith M. Phaneuf, “Bill Cuts Most of This Year’s Deficit,” *Connecticut Mirror*, April 15, 2010, <http://www.ctmirror.com/story/2010/04/14/bill-cuts-most-years-deficit>. Between 2010 and 2013, enrollment in the program grew from 45,000 to 86,000. See Keith M. Phaneuf, “Malloy Takes to Air to Rebut Budget Critics,” *Connecticut Mirror*, May 6, 2013, <http://www.ctmirror.org/story/2013/05/06/malloy-takes-air-rebut-budget-critics>.
 4. Commonwealth Fund, “EPSDT: An Overview,” September 2005, http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2005/Sep/EPSDT%20An%20Overview/893_EPSDT_overview%20pdf.pdf.
 5. See table 2 of Jonathan Gruber, “Medicaid” (Working Paper 7829, National Bureau of Economic Research, Cambridge, MA, August 2000), <http://www.nber.org/papers/w7829.pdf>, for a list of the many incremental legislative expansions of the program from 1965 to 2000.
 6. The HHS waiver database is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.
 7. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>.
 8. As of July 2013. For a current list of pending waivers, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Pending-1115-Demonstration-Applications-.html>.
 9. See the waiver request letter from Governor Mitchell E. Daniels Jr. to Secretary Michael O. Leavitt, February 28, 2007, <http://svcinc.org/PDF/Waiver22807.pdf>.
 10. Timothy K. Lake, Vivian L. H. Byrd, and Seema Verma, “Healthy Indiana Plan: Lessons for Reform” (Issue Brief No. 1, Mathematic Policy Research, Inc., Princeton, NJ, January 2011), http://www.mathematica-mpr.com/publications/PDFs/health/healthyindianaplan_ib1.pdf.
 11. Family and Social Services Administration, State of Indiana, “Background, on the Healthy Indiana Plan Waiver,” FSSA Background, September 3, 2013, http://www.in.gov/fssa/hip/files/BACKGROUND_ON_THE_HEALTHY_INDIANA_PLAN_WAIVER.pdf.
 12. Jesse Cross-Call and Judith Solomon, “Rhode Island’s Global Waiver Not a Model for How States Would Fare under a Medicaid Block Grant” (Washington, DC: Center on Budget and Policy Priorities, March 2011), <http://www.cbpp.org/files/3-16-11health2.pdf>.
 13. The Lewin Group, *An Independent Evaluation of Rhode Island’s Global Waiver*, December 2011, http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf.
 14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended sections of 42 U.S.C.).
 15. Jonathan Gruber, a key advisor to both the Massachusetts and national reform efforts, has repeatedly made the argument that the Massachusetts plan paved the way for the national program, and that if Massachusetts had not gone first, the national effort, in all likelihood, would not have succeeded. See “Romney Defends Mass. Health Care

- Law,” *Boston Globe*, March 30, 2010, http://www.boston.com/news/health/articles/2010/03/30/romney_defends_massachusetts_health_care_law/?page=full. Governor Mitt Romney maintained in the 2012 presidential campaign that the Massachusetts plan was suited only to Massachusetts and would not work nationally. See Avik Roy, “Romney’s Revenge: Romney said His Bay State Health Reforms Weren’t Necessarily Suited to Other States. Few Listened,” *National Review Online*, June 18, 2013, <http://www.nationalreview.com/article/351197/romneys-revenge-avik-roy>.
16. Denials of Medicaid waiver requests are often not the end of the story. States frequently ask permission to make changes in their Medicaid program, are denied, and then come back to HHS with an amended request that might meet approval. This process gives HHS a great deal of power to steer states away from policies that are viewed unfavorably by the federal bureaucracy without issuing a full disapproval of an entire waiver request. See, for instance, Michelle Oxman, “Why CMS Refused Florida Medicaid ‘Reform’ Waiver,” *Law and Health Blog*, Wolters Kluwer, February 21, 2012, <http://health.wolterskluwerlb.com/2012/02/why-cms-refused-florida-medicaid-reform-waiver/>.
 17. Cynthia Shirk, “Shaping Medicaid and SCHIP Through Waivers: The Fundamentals” (Background Paper No. 64, National Health Policy Forum, Washington, DC, July 2008), http://www.nhpf.org/library/background-papers/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf.
 18. A baseline is a budget projection based on current law and current policy. The concept is intended to create a set of figures from which alternative policies, including law changes, can be measured. For a longer discussion of the concept of budget baselines, see Timothy J. Muris, “The Uses and Abuses of Budget Baselines,” in *The Budget Puzzle: Understanding Federal Spending*, John F. Cogan, Timothy J. Muris, and Allen Schick (Stanford, CA: Stanford University Press, 1994).
 19. House Budget Committee, “The Path to Prosperity: A Responsible Balanced Budget,” March 2013, <http://budget.house.gov/uploadedfiles/fy14budget.pdf>.
 20. See Pamela J. Loprest, “How Has the TANF Caseload Changed Over Time” (Brief 8, Urban Institute Washington, DC, March 2012), http://www.acf.hhs.gov/sites/default/files/opre/change_time_1.pdf; and Congressional Budget Office, “Changes in the Economic Resources of Households with Low-Income Children,” May 2007, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/81xx/doc8113/05-16-low-income.pdf>.
 21. Fred Upton and Orrin Hatch, “Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs,” May 2013, <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf>.
 22. See Cong. Rec. 19185, vol. 141, no. 207 (December 22, 1995), <http://www.gpo.gov/fdsys/pkg/CREC-1995-12-22/pdf/CREC-1995-12-22-pt1-PgS19185.pdf>.
 23. For a more detailed description of this concept, see James C. Capretta et al., “Assuring a Future for Long-Term Care Services and Supports in Texas” (Austin, TX: Texas Public Policy Foundation, December 2012), <http://www.texaspolicy.com/sites/default/files/documents/2012-12-RR09-AssuringFutureLongTermCareServices-CHCP-Capretta.pdf>.
 24. For a discussion of the success of the Medicare drug benefit, see James C. Capretta, “Congress Should Not Undermine What Works in the Medicare Drug Benefit” (Web Memo 3360, Heritage Foundation, Washington, DC, September 9, 2011), <http://www.heritage.org/research/reports/2011/09/medicare-drug-benefit-model-for-broader-healthcare-reform>.

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