HEALTH CARE

Ideas for reforming Medicaid and protecting patients

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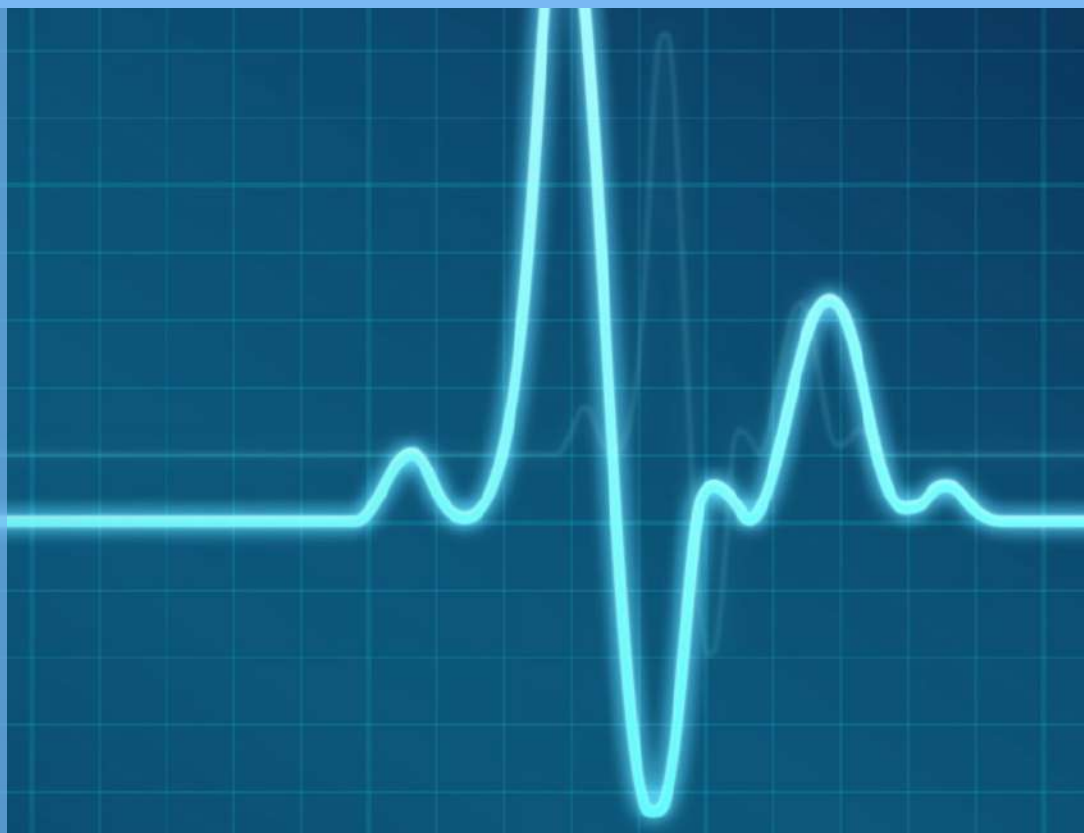

MOUNTAIN STATES
POLICY CENTER

Ideas for reforming Medicaid and protecting patients

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INTRODUCTION

Medicaid is a joint federal and state-controlled health care insurance entitlement. It is not financially sustainable in its current form unless the federal debt or taxes are significantly increased. This paper explores ways that states can reduce the financial burden for their taxpayers, while ensuring that their most vulnerable citizens continue to have access to health care coverage.

History

Medicaid began in 1965 as part of President Lyndon Johnson's Great Society.[1] The Medicaid program was added as Title XIX of the Social Security Act. As an entitlement, the new law committed federal and state taxpayers to paying for health services, regardless of cost, for all U.S. residents who meet the eligibility requirements.[2] Eligibility was initially defined as:

- All children in families with incomes of less than 133% of the federal poverty level (FPL)
- All adult caretakers of eligible children
- Elderly people not receiving supplemental social security benefits
- The legally blind
- The disabled

Medicaid was set up as a joint federal and state program, with Washington, D.C. providing broad national guidelines and individual states deciding the type, duration, and amount of health services to be provided, as well as specific eligibility criteria. The federal government would match state spending on a one-to-one basis. But over the years, the federal percentage has increased from 50 percent to 70 percent for poorer states.

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[1] "State Abuse of the Medicaid Program," available at https://www.washingtonpolicy.org/library/docLib/Feb._2010_MedicaidAbusePB.pdf
[2] "CMS' program history," available at https://www.cms.gov/about-cms/who-we-are/history

KEY INFORMATION COLUMN

The original thinking in Congress was that a joint program would protect taxpayers because state legislators would not be as willing to spend state dollars on an entitlement plan. The rapid expansion in the eligibility and cost of the program since then, however, has shown this supposition to be false. The opposite has occurred. State lawmakers have greatly expanded the program in their pursuit of federal matching dollars.

States that wanted to participate in Medicaid were required to submit a comprehensive plan to the Medicaid office in Washington, D.C. Officials in all 50 states did so. Although the federal guidelines were intended by Congress merely to set broad parameters, the original regulations ran to 220 pages of single-spaced type and included specific mandatory eligibility and benefit criteria.

Originally, not all poor people qualified for Medicaid. Eligibility requirements based on income have been a moving target for state officials through the years and have led to a variety of added state-only programs for the poor and for uninsured people who are not covered by the federal Medicaid program. Instead of holding down Medicaid costs, states have historically sought ways to increase spending in an effort to secure more federal matching funds. For example, in the Omnibus Reconciliation Act of 1980, Congress enhanced the flexibility of states to provide payments for nursing facilities.[3] This act established that states were allowed to set nursing home rates in accordance with their perceived "needs."

Another common method that states use to increase Medicaid spending is to tax providers. Since the 1990s, states have collected revenue from the taxation of providers such as hospitals, nursing facilities, and managed care organizations. These taxes count as Medicaid expenditures. The state taxes that providers pay qualify for federal matching payments and are essentially paid back to the providers in higher reimbursements.[4]

The Affordable Care Act (ACA), also known as Obamacare, greatly expanded Medicaid to any low-income, able-bodied American between the ages of 18 to 64.[5] While the original ACA bill forced states to participate in the expansion, the U.S. Supreme Court ruled this provision to be unconstitutional and left it up to individual states to decide on expanding their programs. Forty states, plus D.C., have chosen to expand their programs.[6] Wyoming, Texas, and Kansas are the only states west of the Mississippi River that have not expanded their programs. The enticement in Obamacare for states was an increased federal payment match of 90 percent.

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[3] "DAB No. 129," Departmental Appeals Board, Washington State Department of Social Health and Services, March 22, 1989, at http://www.hhs.gov/dab/decisions/dab1029.htm

[4] "5 Key Facts About Medicaid and Provider Tax," at https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/

[5] "Overview of the Affordable Care Act and Medicaid," at https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid/

[6] "Medicaid Expansion Under the ACA – A State-by-State Guide," at https://govfacts.org/federal/hhs/medicaid-expansion-under-the-aca-a-state-by-state-guide/

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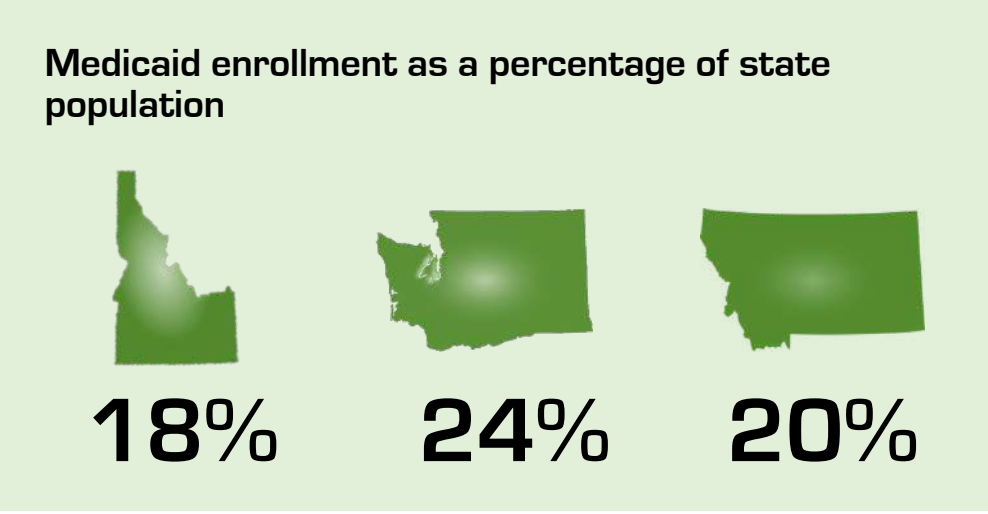
As of May 2025, there were 83 million low-income adults and children enrolled in Medicaid. In other words, 25 percent of all Americans currently have Medicaid as their health insurance.

Enrollment in Medicaid

As of May 2025, there were 83 million low-income adults and children enrolled in Medicaid.[7] In other words, 25 percent of all Americans currently have Medicaid as their health insurance. Thirty-eight percent of enrollees are children, and 24 percent are able-bodied adults who enrolled under the Obamacare expansion.

Over the years, eligibility requirements have changed for various demographic groups. Currently, parents and childless adults are at 138 percent of the federal poverty level (FPL). Children enrolled in the Children Health Insurance Plan, which is part of Medicaid, are at 255 percent of the FPL and disabled individuals can sign up for Medicaid if their income is less than 250 percent of the FPL.



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The exploding cost

Congress did not set an initial budget for Medicaid in 1965. As stated above, it was believed that state legislatures would not greatly expand the entitlement since this would put a larger tax burden on their own taxpayers. The exact opposite has occurred, as states have an incentive to grow the program. For every dollar a state spends on Medicaid, the state receives at least one matching dollar from the federal government. Obviously, this is totally different than state spending on education, transportation, or any other state activity.

[7] "Medicaid State Fact Sheets," at https://www.kff.org/interactive/medicaid-state-fact-sheets/
[8] Medicaid enrollment, Center for Medicare and Medicaid services, available at https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9/data?conditions[0][property]=enrollment_year&conditions[0][value]=2024&conditions[0][operator]=%3D&conditions[1][property]=enrollment_month&conditions[1][value][0]=4&conditions[1][value][1]=5&conditions[1][value][2]=6&conditions[1][operator]=in

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The first year of spending on Medicaid was less than $1 billion inflation-adjusted dollars. Ten years later, spending was up to $13 billion.[9] Last year, spending exploded to $880 billion, with $606 billion coming from federal taxpayers. Of course, state and federal taxpayers are the same people.[10] Medicaid is now one of the largest budget items for every state and is the largest entitlement program for the federal government

Medicaid Expansion Taxpayer Cost[11]

As of 2023

State	Projected Cost	Actual Cost	% Overrun
Idaho	$460,500,000	$880,435,522	91%
Washington	$2,252,894,847	$10,324,820,029	358%
Montana	$429,808,190	$1,037,040,496	141%

The health reality of the Medicaid program

Does having Medicaid health insurance actually save lives or improve health more than being uninsured? Except in very specific cases, the answer is no.

In 2008, Oregon lawmakers decided they only had enough additional public money to add 10,000 people to the state's Medicaid program. Oregon officials held a lottery that ultimately signed up 6,400 new Medicaid enrollees. A further 5,800 people were eligible for the program but were not selected. People in this group had the same health and economic profile as the lottery winners. This created the perfect test case on the effectiveness of Medicaid in providing care. These 5,800 people became the control group in an objective, randomized study.[12]

Having Medicaid health insurance does not improve health outcomes, nor does it improve mortality statistics, compared to having no insurance coverage at all.

The two-year results of the health comparison study were published in *The New England Journal of Medicine*. The conclusion is surprising. It turns out that having Medicaid health insurance does not improve health outcomes, nor does it improve mortality statistics, compared to having no insurance coverage at all. The Medicaid group had no improvement in the important objective measurements of blood sugar levels, blood pressure and cholesterol levels. The study did find that vaguely defined "mental health" did improve, however, this was done via subjective telephone interviews, not objective clinical data. For those few people requiring prolonged medical and hospital treatment,

[9] "Total Medicaid expenditures from 1975 to 2022," at https://www.statista.com/statistics/245348/total-medicaid-expenditure-since-1966/

[10] See Note 7.

[11] Foundation for Government Accountability estimates using data from the Department of Health and Human Services and state Medicaid agencies, available at https://thefga.org/research/medicaid-expansion-budgets-taxpayers-displacing-truly-needy/

[12] "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes," by Katherine Becker, et. al., New England Journal of Medicine, May 2, 2013, at http://www.nejm.org/doi/full/10.1056/NEJMsa1212321

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having Medicaid did improve their financial status because their medical bills were covered by federal and Oregon taxpayers.

Another tragedy for Medicaid patients is limited access to care in some areas because of poor provider payments. States have the leeway to set reimbursement rates for doctors and medical facilities, but traditionally, these payments have been very low. Depending on the medical specialty, Medicaid pays physicians 30 to 50 percent of what private insurance pays. Hospital payments are likewise less than Medicare payments and considerably less than private insurance. No doctor or hospital could pay their overhead and keep their doors open with only Medicaid's poor reimbursements. The reality is that not every provider can afford to see Medicaid patients, which limits recipients' access to care.

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It is very clear that simply having health insurance does not guarantee timely access to health care.

State reform options

Waivers

Although Medicaid is a joint entitlement with federal and state control, in general, states must apply for and receive federal approval for the specific structure of their program. States can use State Plan Amendments for minor changes, such as cigarette cessation programs. These additions only need federal notification, not approval.

Major changes to a state's Medicaid plan, such as adding a premium charge, require federal approval through a waiver process. Temporary changes require a 1135 waiver. Permanent changes require a 1115 waiver. Over the years, federal administrations have had various levels of enthusiasm for waiver approvals.

Return to a Safety Net Program

The original goal of Medicaid was to provide health insurance and medical access for the country's most vulnerable citizens. Elected officials should return their programs to a safety-net plan, where money spent would go toward otherwise unfunded medical care. States should eliminate able-bodied adults and people who have access to other forms of health insurance. States should only use Medicaid dollars for medical care and not for food supplements, transportation, and housing as some states have done.

Work requirement

Obamacare expanded Medicaid to able-bodied people ages 18 to 64. It is very reasonable to make work or community service a requirement for these

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individuals. This would give people a sense of purpose and would provide them with an avenue to improve their lives and leave the welfare program.

Frequent eligibility checks

People's lives are not static. They move from state to state, they change jobs, their income levels improve, and their children ultimately leave home. Eligibility requirements should be checked at least twice a year, if not quarterly. Ideally, an agency outside of government should oversee the checks.

Make Medicaid a temporary entitlement

Welfare reform in the 1990s was successful in large part because it focused on a time limit for receiving aid. Medicaid should be considered the same way. Where possible, it needs to be a transition health insurance program until patients qualify for other forms of health insurance. Medicaid should not be a permanent plan that covers recipients until they are eligible for senior insurance through Medicare.

Allow patients more control of their health care dollars

As it is structured now, Medicaid is an open-ended entitlement. If an enrollee qualifies, they essentially receive free health care without any financial responsibility.

Medicaid enrollees should have a nominal copay requirement based on income. It is not unreasonable to require recipients to pay a small amount to receive otherwise free health care.

Medicaid enrollees should have a nominal copay requirement based on income. It is not unreasonable to require recipients to pay a small amount to receive otherwise free health care. It is condescending to believe poor families cannot manage their own health care. Allowing them to control their own health care dollars through subsidized health savings accounts or a voucher system would financially reward enrollees for leading a healthy lifestyle and making smart personal choices.

Block grants

A reasonable first step for states would be to ask the federal government for a block grant of money. It would force states to prioritize the most-needy patients, which was the goal of the original Medicaid law. This would also place a cap on Medicaid spending, making state budget planning much easier.

Reconsider the Obamacare expansion

For states that expanded their Medicaid programs under Obamacare, reconsidering the expansion would be another way to ensure that the most vulnerable patients continue to have coverage.

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Polling has shown work requirements for able-bodied adults are supported across party lines.

Medicaid reform in Idaho

The Idaho legislature recently passed a Medicaid reform bill into law.[13] The legislation establishes a 20-hour-a-week work or community service requirement for able-bodied enrollees in Medicaid. The law also asks the federal government for waivers to place the state's Medicaid program in a comprehensive managed care plan, as well as a waiver to establish cost-sharing in the program. In addition, the law includes an increase in provider payments to better align with Medicare reimbursements.

The fiscal note estimates a savings of $15.9 million in 2026 and $27.2 million in 2027 and beyond. Although Idaho voters passed the Obamacare Medicaid expansion in 2018, the new legislation is potentially an excellent start at meaningful Medicaid reform.

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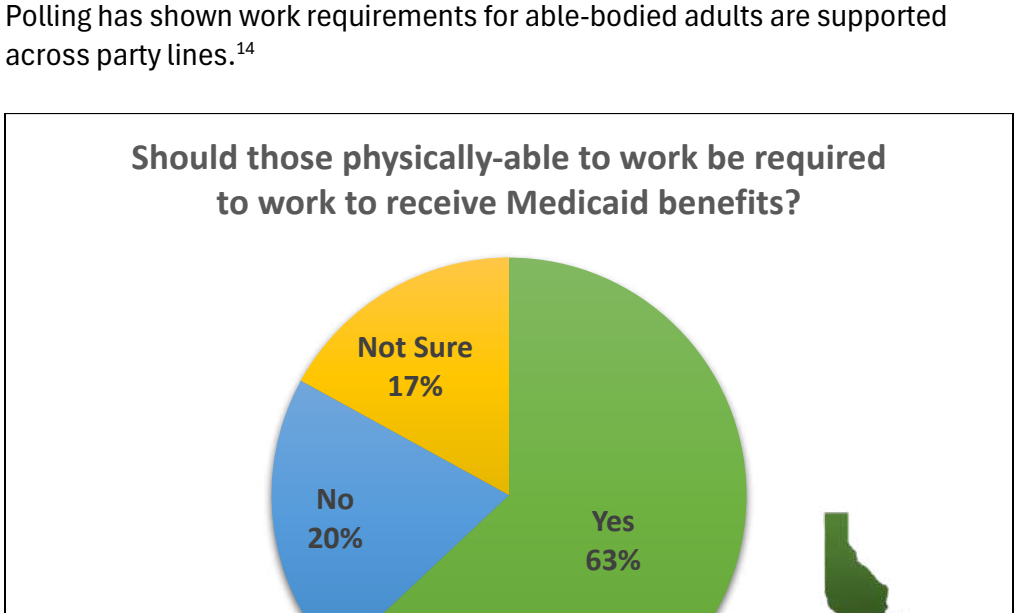

Conclusion

The massive expansion of Medicaid is completely understandable. Elected state officials have looked at the program as a federal piggy bank. They can feel good about providing health insurance to the poor, with the federal government

[13] Idaho House Bill 345, Idaho State Legislature 2025 Session, available at https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2025/legislation/H0345.pdf

[14] Results of the 2024 Idaho Poll, Mountain States Policy Center, December 2024, available at https://www.mountainstatespolicy.org/results-of-the-2024-idaho-poll

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paying over half the costs. In a sense, Medicaid could be considered the first step to a single-payer health care system in the United States. Although it appears that the federal money for Medicaid is "free" money for states, elected officials need to remember that federal taxpayers are also their state taxpayers.

For meaningful reform and to ensure that the most vulnerable patients can still access the program, state officials must be willing to make the necessary changes to the entitlement. They should be willing to go to the federal government and push for sensible reforms. They must be willing to confront criticism and do what is necessary to guarantee Medicaid's viability for those truly in need and for whom the program was originally designed to assist.

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SUMMARY & KEY FACTS

Medicaid, created in 1965 as a joint federal-state health insurance entitlement, has expanded far beyond its original purpose of assisting the most vulnerable citizens and is now financially unsustainable without major increases in federal debt or taxes. Despite enormous spending growth—driven by incentives for states to secure federal matching funds—research has shown that Medicaid coverage does not consistently improve health outcomes compared to being uninsured.

1. **Enrollment -** As of May 2025, 83 million Americans—**25% of the population**—are enrolled in Medicaid.
2. **Cost Growth -** Annual Medicaid spending grew from **less than $1 billion in 1965 to $880 billion in 2024**, with $606 billion coming from federal taxpayers.
3. **Provider Reimbursement-** Medicaid pays physicians only **30–50% of what private insurance pays**, contributing to limited access to care.
4. **Expansion Impact- 40 states plus D.C.** expanded Medicaid under Obamacare, which offers a **90% federal match rate** for newly eligible enrollees.
5. **Idaho Reform -** Idaho's recent Medicaid reform law is projected to save **$15.9 million in 2026 and $27.2 million annually thereafter** through work requirements and managed care waivers.

ABOUT THE AUTHOR

Dr. Roger Stark is a retired physician and author of three books including Healthcare Policy Simplified: Understanding a Complex Issue, and The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It.

He has also authored numerous in-depth studies on health care policy including *What Works and What Doesn't: A Review of Health Care Reform in the States*, and *Health Care Reform that Works: An Update on Health Savings Accounts*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees regarding the Affordable Care Act.

Dr. Stark graduated from the University of Nebraska's College of Medicine, and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. He retired from private practice in 2001 and has been a member of many regional and national professional organizations. Dr. Stark currently makes his home in Utah.

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