What Should New Mexico Do About Medicaid?

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Problem Statement

Since the U.S. Supreme Court upheld ACA (Patient Protection and Affordable Health Care Act of 2010), everyone is wondering what will happen to American health care? The President expects the country to accept total government control. Republican challenger Mitt Romney vows to repeal ACA as soon as he is elected.

Meanwhile, states must decide what they will do about the ACA mandates. Implement Health Exchanges or not? Expand Medicaid or not?

New Mexico Governor Susana Martinez initially rejected a Democrat-devised health exchange, but now is moving forward with an exchange of her own design. To date, she and her team have not decided what to do about Medicaid expansion embodied in the ACA. The same is true of over half the States.

Medicaid and Medicare

Many people lump Medicaid and Medicare in the same breath. Both are federal entitlements that spend massive sums on healthcare. Together, they account for 23% of all Federal spending. Medicaid plus Medicare spent $835 billion in 2011. That is $110 billion more than Social Security.

Medicare is very different from Medicaid. Medicare was originally intended as pay-in-advance insurance plan, not government welfare. People would pay in to the Fund while working (between 25 and 65 years of age). The government would keep the money in a virtual lockbox and invest it to make it grow. After age 65, there would be enough money in Medicare to pay for each senior citizen's health care needs.

Medicare will run out of money by 2017 for three reasons. First, immediately after passage of the law in 1965, Congress broke open the "lockbox" of the Medicare Trust Fund and put the money into General Accounts, where it could be used for any purpose. Congress replaced the cash with IOU's, which could not be invested and therefore could not grow. Second, within three months of the passage of Medicare, 12 million Americans over age 65 demanded benefits. These were people who had not put money into the Fund: not for forty years, indeed not for any years.

Third and most important, Medicare has a fatal design flaw. It offers benefits without limits, but has a fixed amount of money to expend. Any economist will tell you that a system with unlimited demand and limited supply is unstable. Medicare cannot survive.

In contrast to Medicare, Medicaid was always intended as an entitlement program. Medicaid enrollees do not pay in advance into a Fund, as Medicare requires. Medicaid is an amalgam of three different group entitlements: 1) Children, originally the AFDC (Aid to Families with Dependent Children) program; 2) Poor people, at or below the national poverty line; and 3) Categorical, by illness or disability, such as birth defects or chronic kidney disease. Today's Medicaid covers all three groups.

Medicaid Programs are joint endeavors of each state and the federal government. The national average is one dollar from the state matched by two from Washington. *Medicare* pays providers and institutions. *Medicaid* does not. Its dollars are funneled into various insurance carriers who bid for contracts, enroll as many people as possible, and try to spend as little on health care as they can get away with for obvious reasons.

Medicaid rewards (pays) doctors when patients are sick but not when we are well. It rewards insurance carriers (with profit) when they delay, defer or deny care, not when they authorize it. This is a paradigm of perverse incentives: rewarding what We The Patients don't want and punishing what we do.

Wait! Are we sure we know what we want from Medicaid? What would a successful Medicaid program look like?

A successful Medicaid program would be one that a) assures and improves the health of the entitled populations b) at an acceptable price. As a (free) entitlement, the expenses of the program are paid by society, not by the individuals, presumably because they are unable to pay for the health care they need.

A note on semantics is necessary. As two words, health care refers to a service relationship between a patient and a provider. The single word – healthcare – denotes a system that is supposed to facilitate the two words (the service) health care.

There are two metrics for Medicaid success: medical outcomes and fiscal results.

Evidence of medical outcomes

Fixing a sick system such as Medicaid is just like curing a sick person. They both require careful evaluation of past experience: rigorous analysis of evidence. [1] What does evidence tell us about patient outcomes in patients covered by government health insurance?

Avik Roy, based on a 2010 University of Virginia post-operative study, called Medicaid a "humanitarian catastrophe." [2] He found that the in-hospital death rate for surgical patients with private insurance was 1.3%. Medicare, uninsured, and Medicaid patients were 54%, 74%, and 97% more likely to die than those with private insurance.

An earlier study in California of HIV-infected patients showed an 8% HIGHER likelihood of dying among Medicaid patients than those who had no insurance whatsoever.

Some studies have suggested that Medicare patients do better than the uninsured. [2, 3] On detailed inspection, these reports actually first showed worse outcomes and only after statistical manipulation (chicanery) did the results come out "right," i.e., politically correct.

Having an academic debate with one side brandishing its evidence and the other countering with contradictory data is pointless. What matters is this. Without clear, unequivocal proof that having Medicaid coverage makes patients healthier, it seems foolhardy in the extreme to expand this government health entitlement program.

Evidence of fiscal outcomes

We are all both patients and voters. Therefore, we are interested in both medical outcomes and fiscal results. In a recent *Albuquerque Journal* Op-Ed piece, a physician implored the New Mexico legislature to expand Medicaid on the grounds that it is "free money." [4]

Table 1 shows the results of the New Mexico Legislative Finance Committee study on expanding Medicaid. Superficially, this looks like a great deal for a State where the entire general fund budget was only $5.6 billion in 2012.

Table 1: NM State Finances & Medicaid

Year	# Enrollees	Spending, billions (b) $$	
		New Mexico	Federal
2014	587,103	0.95b	2.7b
2020	Natural growth, no program expansion		
	651,000	1.2b	3.3b
2020	Medicaid Program Expansion – low estimate		
	758, 000	1.5b	4.5b
2020	Medicaid Program Expansion – high estimate		
	799, 000	1.7b	6.2b

Estimates from New Mexico Legislative Finance Committee [5]

While Table 1 may look like free money, we all know: a) there is no such thing; b) who will *not* get the money – providers; and c) who will *not* get services – patients. Medicaid will follow the same path as Medicare. More and more money will go to the bureaucracy, while less and less will go to people who actually care for patients.

Table 2 shows a current Medicaid payment schedule. [6] First note the charges for various services. Since most people believe that what is charged is what is paid, they think that Medicaid doctors are doing well financially. Not so. Medicaid pays what it chooses, regardless of the charge or the value.

Putting a tube (bronchoscope) down the throat of a child who can't breathe or threading a catheter inside the heart of a newborn (size of a strawberry) is a time-consuming, dangerous, highly stressful procedure that requires decades of training and experience. Are $304 or $465 appropriate compensation? Do you still believe that doctors are getting rich from caring for Medicaid patients, when they are paid 20-43% of reasonable charges?

Table 2: Medicaid Fee Schedule (2012)

Service	Charge	Payment	Ratio
Well child check-up	$182	$ 51	28%
Consult by specialist	$250	$108	43%
Visit for illness	$130	$ 51	39%
Admission to hospital	$350	$111	32%
Bronchoscopy	$1,484	$304	20%
Diagnostic heart catheterization	$2,218	$465	21%

The number of physicians refusing to see Medicaid patients is up to 31% and rising [7] This is because government payments do not cover their fixed costs. Accepting more Medicaid patients makes them close their office doors. Then who will care for any patients?

Even as the ACA spends over $1 trillion, it cuts payments to providers by over $500 billion. It takes money from care services and gives the funds to a massively inefficient and insupportably expensive federal healthcare bureaucracy. One look at the Medicaid Information Technology Architecture[8] or an organizational chart [9] for ACA proves this point.

If New Mexico expands Medicaid, more money may come in, but it will go to bureaucrats, not for patient needs. Note that I wrote, "may come in." The federal government is very profligate with promises, especially during election season, but miserly with actual payments. Once a State increases its eligibility standards, it cannot take them back. So there will be more patients clamoring for more care and thus more expenses, but no more federal dollars and no doctors. Still think Medicaid expansion is a great deal?

Free market forces in healthcare

Medicaid currently controls both sides of the so-called healthcare market: supply and demand. Tight control is precisely the opposite of a free market. Central control has produced what you see in the tables above. Central control is taking Medicare into bankruptcy. Central control with its ever-expanding government bureaucracy and regulatory burden is exploding our healthcare spending and taking the U.S. toward national bankruptcy.

What if we reduced central control and added some free market forces to healthcare? What would happen?

Good data comes from a pilot study in Florida started in 2006 and reported in 2011. [10] Florida Medicaid gave to its citizens a measure of control over their own health care dollars. Results were impressive. Services expanded and patient satisfaction went up. At the same time, sizeable reductions in spending were observed: 17% overall and 11% for the (most costly) elderly or disabled. The pilot project was only in five counties. Had the whole state been involved, Florida would have realized savings of nearly $1 billion.

Yet Washington wants to expand government control, subsidies, and dependency. Under the ACA, all three categories of Medicaid eligibility will be expanded: age, income, and categories. People will be eligible up to age 26 years. Why only till 26? Why not 30, or 50, or till death?

The income threshold will increase to 400% of the national poverty line. That translates to families-of-four earning $88,000/year. Starting in 2014, on income alone, 79% of the entire U.S. population will be eligible for federal Medicaid subsidies! And many more medical conditions will be included as eligible for support making over 80% of the U.S. dependent on government largesse.

Is an expanded welfare state and rationing of healthcare what we really want?

Medical Rationing

In everyday usage, to ration means “to restrict to limited allotments,” for example, scarce commodities like rubber during wartime. In economics, rationing means balancing supply and demand, particularly when one is in greater quantity than the other. When supply is greater than demand, the price goes down in a free market. When demand is greater than supply, as in a controlled market like healthcare, the price cannot go up, so the supply is restricted (rationed) by the central authority.

Any one who passed first year Economics will tell you that there are two and only two ways to balance (ration) supply and demand: 1) centrally – by government decisions, or 2) diffusely – allowing market forces, such as consumer decisions and price variability, to create a balance. The first is the socialist approach and the second involves capitalism.

Nations such as Canada, Great Britain, Spain, and Italy already employ central (government) rationing of health care. What this means for the average person is that the national budget determines what health care you get, or don’t get. In England, since kidney dialysis over age 55 and heart surgery over 65 were deemed “not cost effective,” people over those age limits simply die … needlessly.

In Canada, patients wait for months, even years (if they survive that long), to get care. Canadians ration by queueing while in Great Britain, they do it by disapproval. For us, it makes no difference. Either way, We The Patients do not get the care we need.

The same thing that happened to Medicare patients under ACA will happen to Medicaid enrollees. [11] Money will be taken from providers and given to bureaucrats. The result is less patient services, but more regulators and compliance overseers.

Medicaid has already begun to ration our health care. Sixteen U.S. states have started setting limits on the number of drug prescriptions that Medicaid patients are allowed to fill.[12]

Who is your doctor?

This is most definitely not a rhetorical question. Can you choose your own healer of physical and mental ailments?

The law is clear. Only your chosen licensed physician can practice medicine on you. Legal precedents preclude either an insurance *medical* director or a *medical* organization such as an HMO or ACO from acting as your doctor. [13-15] Apparently, this is not true of a *political* organization called the federal government. It can and does act *in loco iatros,* latin for "in place of your doctor."

Everyday, bureaucrats – managers, administrators, overseers, regulators, and legislators – make decisions that directly impact you and your medical care. The ACA tells you what types of medical coverage you are required to purchase, by law. The IPAB tells your doctor what treatments she or he can use and which ones are not available. Whatever your definition is of practicing medicine, the Federal government is doing it.

What should We The Patients do?

To cure Medicaid we need to practice good medicine on it. That means treating causes not symptoms. The last thing we want is to kill patient healthcare, yet that is precisely what Washington is doing.

Two of the primary reasons or root causes of healthcare sickness are disconnection and dollar inefficiency. Disconnection means separating people from their money. Always keep this in mind. It IS our money the government is spending, not its own: over $8,800 per year per person in the U.S. for healthcare the system, not for patient care. When employer-paid health insurance is tax-deductible but insurance you buy on your own is not, that disconnects you from your money by selective government subsidy.

Disconnection also separates behavior from preferred outcome. As Stephen Kerr [16] emphasized almost fifty years ago, we want "A" but reward "B" and then we are surprised when we get "B." We want health but the system rewards sickness care. So what do we get lots of?

There are different approaches that have worked that restore market forces to healthcare. Singapore has one of the most successful healthcare systems in the world. It also has patients opening their own wallets to pay for care, even the poorest citizens.

Here in the U.S. there was the dramatic success of welfare reform in California. [17] This was based on reducing, not increasing, government dependency. Medicaid expansion under ACA would increase government subsidies and therefore dependency to 79% of the whole nation!

Though the Reagan/Carleson success story happened over 40 years ago, it is just as relevant today. Recall (above) the recent success in Florida by giving control of spending to the individuals rather than to some faceless regulator in Washington or even Tallahassee who has no 'skin in the game.'

Block grants and the accompanying fiscal responsibility as proposed by doctor-U.S. Representative Randall Paul are another way to take financial control out of Washington and give it to We The Patients.

Dollar inefficiency in healthcare means money that goes in to the healthcare system that produces neither good health nor health care service. Recently, Washington has made fraudulent Medicare doctors and laboratories a target, saying we need to reduce their theft of vitally needed resources. This is ironic and a diversionary tactic.

Pointing a finger at others diverts attention from the biggest theft imaginable. While dishonest providers and unscrupulous companies contribute steal millions of dollars, the Federal Fraud is 100,000 times worse. It steals trillions [18] of dollars that could and should go to patients.

The "Federal Fraud" is based on public acceptance of the following. A) We The Patients need the rules and regulations to protect us and to improve our health. B) We don't pay for the regulations and the attendant bureaucracy: they are free. C) Rules, regulations, and the attendant healthcare bureaucracy are highly valuable, they are worth the expense.

Evidence proves that all three are false.

A) While logic might suggest that the regulations are good for our health, there is no, repeat no, proof. Imagine spending $1 trillion a year on a wing-and-a-prayer.

We all seem to suffer from a blind side – a sort of pirate's eye patch on one eye. When we are sick *patients*, we demand hard scientific evidence from those who directly practice medicine on us. As *voters*, we apparently make no demands for evidence from those (legislators) who practice medicine on us indirectly, in their treatment plan for sick healthcare.

B) The regulatory bureaucracy consumes 40% – $1.08 trillion in 2011 – of all healthcare spending. You, reader, like every other American, paid $3520 out of pocket for government healthcare bureaucracy. In no aspect of American life was Ronald Reagan more accurate than healthcare spending, when he said, "Government is the problem, not the solution."

C) No one, repeat no one, does proper cost/benefit analysis in healthcare (the system) or for health care (the service.) What are the benefits of healthcare and health care? Has anyone measured them? Without a denominator, you cannot have a ratio such as cost/benefit. Without cost/benefit, one cannot determine the value of healthcare to We The Patients.

And now they want to expand Medicaid, hoping and praying (no proof) that it will be good for us and that it will be worth the expense. The evidence suggests the opposite. Expansion will make the system and the people sicker – by increasing both disconnection and dollar inefficiency. Want a final proof? Consider the country Spain.

The 1978 Spanish Constitution explicitly makes the government responsible for the health of its citizens. By law, Spaniards are not responsible: the government is. In American terms, Spaniards are all government-dependent, not free and independent.

What is the evidence of outcomes in Spain? Spain has an extremely high infant mortality rate, very low growth rates in both population and life expectancy, and some of the European Union's highest rates of HIV, venereal diseases, drug addiction, and tuberculosis. And as we all know, Spain is going broke.

Sir Winston Churchill said, "The inherent vice of capitalism is the unequal sharing of blessings. The inherent virtue of socialism is the equal sharing of its miseries." Americans would prefer an unequal but broadly healthy populace to an equally, uniformly, and politically correct sick citizenry.

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