

AN
UNSUSTAINABLE  PATH

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The Past and Future of
Kentucky Medicaid Spending



An Unsustainable Path: The Past and Future of Kentucky Medicaid Spending
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**An Unsustainable Path:
The Past and Future of Kentucky Medicaid Spending**

John Garen, Ph.D.

June 2011

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| | |
|---|-----------|
| Executive Summary | 3 |
| I. Introduction | 5 |
| II. Some Basics of Medicaid | 6 |
| III. National Trends in the Medicaid Program - | 9 |
| IV. The Efficacy of Medicaid | 11 |
| V. Medicaid in Kentucky | 13 |
| VI. Medicaid Reform | 19 |
| VII. Conclusion | 26 |
| Appendix: Full-Scale Charts | 27 |
| About the Author | 30 |
| References | 31 |

EXECUTIVE SUMMARY

Kentucky Medicaid is on an unsustainable path. Its expansive spending growth over the past 25 years has put increased pressure on state and federal budgets. Medicaid has failed to fulfill the goal of improved health for most of its recipients. The recently passed Patient Protection and Affordable Care Act (PPACA) did not enact any fundamental reforms in Medicaid but expanded the program dramatically. Kentucky and the nation deserve much better regarding serving the taxpayers and in crafting a program that assists the truly needy.

Growth of Medicaid Nationally

- From 1999 to 2009, total spending on the Medicaid program rose by 55%, from \$248 billion to \$384 billion (in constant 2010 dollars).
- The number enrolled in the program nationwide rose by 47%, from 32 million to 50 million, with only a small portion of increase attributable to the recent recession.

Growth of Medicaid in Kentucky

- From 1999 to 2009, total federal and state spending on Kentucky's Medicaid program rose by 54%, from \$3.3 billion to \$5.1 billion and Kentucky's general fund spending on Medicaid increased by 37%, from \$802 million to \$1.1 billion.
- The number of Kentuckians enrolled in the program grew from about 664,000 to roughly 924,000, or 39%.
- These increases occurred during a time where real U.S. GDP grew by 19% and Kentucky's by only 8% and followed a decade (1989 to 1999) of even more dramatic increases in the Medicaid program.

Unsustainable Path of Kentucky Medicaid

- This is part of the entitlement spending predicament in the U.S.: large and rapidly growing budgetary commitments that outstrip GDP growth and threaten the fiscal solvency of the federal and state governments.
- Straightforward projections into the future indicate that this problem will worsen for Medicaid as currently structured and is exacerbated by the enactment of the Patient Protection and Affordable Care Act (PPACA) that expands eligibility to a larger population.
- Our projections indicate that by 2020, total Medicaid spending (federal and state) on Kentucky will be 63% higher than in 2009 without PPACA and 80% higher with PPACA.
- Kentucky's general fund spending on Medicaid projects to be 70% higher without PPACA, and 80% higher with it.

Efficacy of the Medicaid Program

- Though Medicaid expansions have been portrayed as helpful to children, many studies indicate that past Medicaid growth came at the expense of private insurance, where over half of additional enrollees from these expansions would otherwise have had private health insurance.
- Improvements in access to healthcare and in health status for new enrollees have been minimal, aside from the small minority of recipients who are extremely poor.

Problematic Incentives

- Medicaid is rife with incentives that thwart budgetary control and good healthcare practices on the part of consumers and providers. These include:
 - Under-reimbursement for many healthcare services for Medicaid patients that penalize providers for taking these patients

- Lack of co-pays and deductibles for healthcare services used by Medicaid recipients that leads to misuse and overuse of healthcare
- “One-size-fits-all” medical coverage that does not allow shopping for insurance that best suits the individual
- Few provisions that encourage healthy lifestyles or discourage unhealthy habits
- Matching federal funds for state Medicaid expansions that reward states for growing their programs
- Incentives to limit work effort to avoid crossing the income threshold where Medicaid benefits are lost
- Poorly targeting the population of truly needy individuals and families such that many in the middle class are eligible for Medicaid benefits

Essentiality of True Reform

- The unsustainable path of Kentucky’s Medicaid program necessitates fundamental reform to provide for the commonwealth’s most vulnerable citizens and to prevent future cuts to other budgetary categories and provider reimbursements.
- The attainment of vibrant competitive markets rewards consumers for being smart shoppers for insurance, doctors, and medical treatment, thereby rewarding providers for effective treatment and service.
- Substantial doses of choice and competition will benefit the healthcare sector generally and those benefits would accrue to the low-income population seeking health insurance as well as to public programs designed to assist the healthcare purchases of the poor or other needy groups.
- While strong, competitive markets in this regard will eliminate the need for public health insurance for most, there will remain a group of individuals who are truly needy, due to low earning capacity or precarious health conditions, who will need healthcare assistance. It is this group that public health insurance should focus on.

Path to Reform

- Effective reform of Medicaid would ideally include measures to improve competition in the healthcare and health insurance markets. We point to several solutions for reforming the system in Kentucky:
- Medicaid can be transitioned to a health insurance voucher (premium support) program, with the voucher amount determined by income and health condition, encouraging competition and choice.
- The program also should be converted to one where federal funding is in the form of a block grant and flexibility is allowed for each state. This removes incentives for states to “game” the system to receive more federal matching money as well as enabling states to design programs that suit them best.

When President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law, the Medicaid program was enacted. It created a joint federal and state healthcare program designed primarily to help low-income individuals, the disabled, and the elderly. Initially, the program was small, covering less than 10 million persons at a cost of around \$11 billion (in constant 2010 dollars), but has grown dramatically so that, as of 2009, over 50 million people were enrolled in Medicaid, costing federal and state taxpayers over \$380 billion. This growth has been especially pronounced over the past 25 years and is part of the entitlement spending crisis that threatens the fiscal soundness of the federal government as well as state governments. This spending growth, in addition to concerns about the efficiency and effectiveness of the Medicaid program, prompts this report. Moreover, the recently passed federal Patient Protection and Affordable Care Act (PPACA) did not enact any fundamental reforms in Medicaid but expanded the program dramatically. Thus, it seems that there will be even further budgetary stress on states and the nation unless significant reform occurs.

One purpose of this report is to document the evolution of Medicaid for the nation as a whole and for Kentucky in particular in order to illustrate the path to the current budgetary crises. A second purpose is to demonstrate the size of budget pressures in Kentucky coming in the near future with

Medicaid as augmented by PPACA, which are quite substantial. Third, in addition to the budgetary implications, we examine the evidence regarding the historical effectiveness of Medicaid in enhancing the coverage and health of eligible groups. As discussed below, we find very disappointing results in this regard. A fourth purpose is to provide an overview of potential reforms in the Medicaid program, both large and small, to more effectively enable individuals to attain quality medical care, to promote efficiency and fiscal soundness, and to target public assistance at the truly needy. While we do not attempt to design a specific reform proposal, we do discuss broad approaches to reform, stress the dysfunction incentives in the Medicaid program, and the importance of moving to reforms that engage the private sector and embrace market-like incentives.

“Initially, the program was small, covering less than 10 million persons at a cost of around \$11 billion (in constant 2010 dollars), but has grown dramatically so that, as of 2009, over 50 million people were enrolled in Medicaid, costing federal and state taxpayers over \$380 billion.”

II. SOME BASICS OF MEDICAID

Medicaid is the primary government health plan for various low-income groups. It is jointly administered and funded by states and the federal government. States offer Medicaid to their citizens and are required to follow federal minimum guidelines regarding who is eligible and what medical care is covered. The federal government funds a minimum of 50% of the cost of the program. The federal share is based on a state's per capita income; the lower the per capita income the larger the federal share.

When the Medicaid program began, coverage was primarily for low-income single-parent families whose incomes fell below a certain threshold. It has grown over the years by covering low-income two-parent families and by semi-regularly raising the income eligibility standards substantially above the poverty line for children and pregnant women. Expansions during the late 1980s and early 1990s were especially large, as was the expansion in the late 1990s that created the related State Children's Health Insurance Program (SCHIP). Medicaid is composed of other programs as well. There is a program for low-income people who are aged, blind, disabled or deemed medically needy, though this group is small in number. Also, Medicaid covers nursing home expenses for the elderly whose assets fall below a certain level.

Total Medicaid enrollment during 2009 was 50.1 million individuals, or 16% of the population. Of

these, nearly half were children and almost a quarter were adults outside of special categories. Children and adults together accounted for roughly one-third of expenditures on the program, with the aged, blind, and disabled accounting for two-thirds. Combined federal and state spending for 2009 totaled \$384 billion (in 2010 dollars).

States are required to cover a certain set of major medical services but have the option of increasing coverage beyond this. States in fact extend coverage well beyond the minimum; most cover dental, eye care, mental healthcare, prescriptions, and transportation.¹ Also, deductibles and co-payments are negligible. Some have commented that the package of services provided is more generous than most private health insurance plans.

An issue related to this, however, is the reimbursement to medical care providers for Medicaid patients. Medicaid allows providers to charge specified rates that tend to be low relative to that for other patients, especially for physician services. A number of surveys and studies indicate that large percentages of physicians do not accept or limit acceptance of Medicaid patients. There are various reasons why this is so, but important reasons include Medicaid's inadequate and delayed reimbursements.² These latter two points are both quite paradoxical.

¹ See U.S. GPO (2004), Table 15-15.

² See, for example, Sommers, et. al. (2011).

SOME BASICS OF MEDICAID

It seems odd to set up an aid-the-poor program to provide healthcare services that exceed even what most people cannot or do not buy. Equally peculiar is to “cover” these services, but fail to establish adequate payment to suppliers of those services.

This is one of a host of ill-advised incentives imbedded in the Medicaid program:

- The under-reimbursement for various medical services for Medicaid patients generates a financial penalty to providers for serving Medicaid patients instead of other patients. Thus, there is financial reward from avoiding the very group that the policy is intended to help.
- Each state designs a single policy for all people within each class of eligibles and the policy is essentially free to those individuals. Thus, there is no opportunity or any incentive to shop for the health insurance policy that best suits each person. Moreover, there are no provisions to discourage unhealthy lifestyles, e.g., there are no penalties for smoking, alcohol overuse, poor diets, lack of exercise, all of which cause more use of the healthcare system.
- The minimal deductibles and co-pays for medical care encourage Medicaid users of medical services to ignore the costs of those services, even for elective and non-emergency services. This leads to overuse and misuse of healthcare.
- The paradox of the three previous points is that Medicaid-covered users of medical services have a financial incentive to use more medical care while the providers have incentive to provide less.

“...Medicaid-covered users of medical services have a financial incentive to use more medical care while the providers have incentive to provide less.”

- The federal matching of state funds by at least dollar-for-dollar makes it easier for states to expand Medicaid coverage, while increasing the difficulty of cutting back. For example, Kentucky’s enhanced federal matching rate is approximately 80%. Thus, for each additional dollar of state Medicaid spending, total Medicaid expenditures for Kentucky rise by \$5.00 (\$1.00 of state funds, \$4.00 federal funds); for each dollar cut from Kentucky’s state Medicaid budget, Medicaid spending falls by \$5.00. Additionally, states are rewarded with matching federal funds for budget manipulations that give the illusion of higher state contributions.

SOME BASICS OF MEDICAID

- Medicaid benefits are available for those below a certain income threshold and are completely lost once the threshold is crossed. Thus, there is an incentive to limit work effort so that income does not cross this threshold.³ For example, parents of a family of four in Kentucky qualify for Medicaid for themselves if their income is less than \$13,857 and lose all Medicaid benefits for any income above that amount.
- Long-term care for the elderly is available only if the recipient's assets fall below a certain threshold. This has elicited many strategies to "spend down" the assets of the elderly (e.g., via "gifts" to children) to become eligible for Medicaid-provided nursing home care and has triggered regulations to try to limit these strategies. Additionally, evidence suggests that the availability of the Medicaid option has eliminated much of the market for private long-term care insurance.
- Medicaid coverage for children reaches well outside the low-income population in many states so that it is no longer well-targeted to the poor. For many states, the children of families of four can obtain Medicaid for incomes up to \$67,050. For Kentucky, this income threshold is \$44,700.
- This poor targeting has resulted in numerous families who could afford private coverage that drop out of the private insurance market in favor of taking up the Medicaid program.

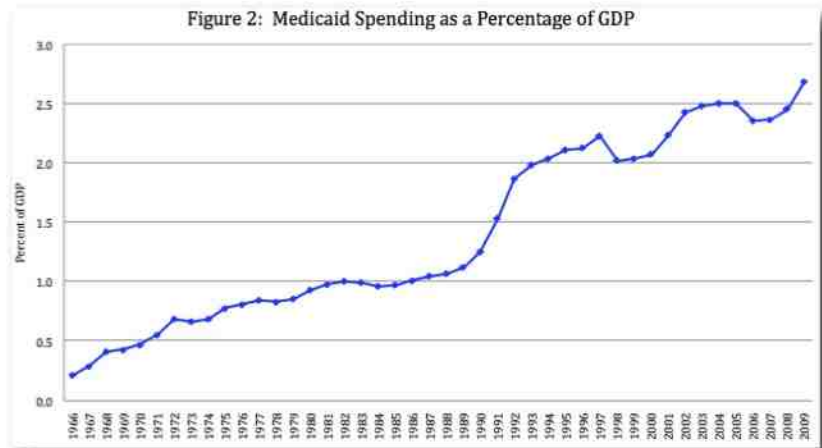
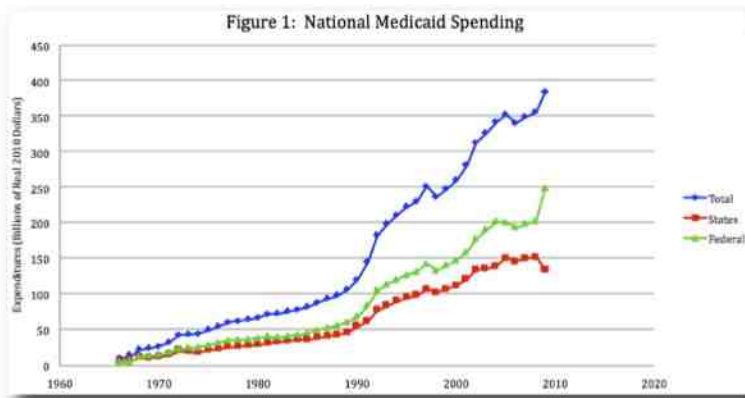
Each of these is a non-trivial issue that generates the above-described problems as well as raising the cost to the taxpayer of the Medicaid program. It is important that reform efforts deal with these issues, while maintaining a sensible safety net for the truly needy.

“...the availability of the Medicaid option has eliminated much of the market for private long-term care insurance.”

³ For evidence, see Yelowitz (1995).

III. NATIONAL TRENDS IN THE MEDICAID PROGRAM

Medicaid began as a relative small program both in terms of budgetary commitment and recipients, but has grown both in number of recipients and in dollars spent to become the third largest domestic program in the federal budget. As exhibited in Figure 1, real total outlays on Medicaid grew steadily but slowly through the 1960s, 1970s, and early 1980s, rising from \$11 billion to just over \$80 billion by 1985. Large expansions of the program during the late 1980s and early 1990s pushed total spending up to over \$220 billion in the single decade of 1985 to 1995. In the following decade, further expansions occurred so that real spending jumped again to \$352 billion (in 2005) and as of 2009 was approximately \$380 billion. Figure 1 also shows how total Medicaid spending is composed of federal and state funds. State funding typically has been about 45% of the total (though this varies greatly from state to state), so the financial obligations of the states has risen along with the growth of the program, though during the



recent recession, the federal government took on a larger than usual share of expenditures.

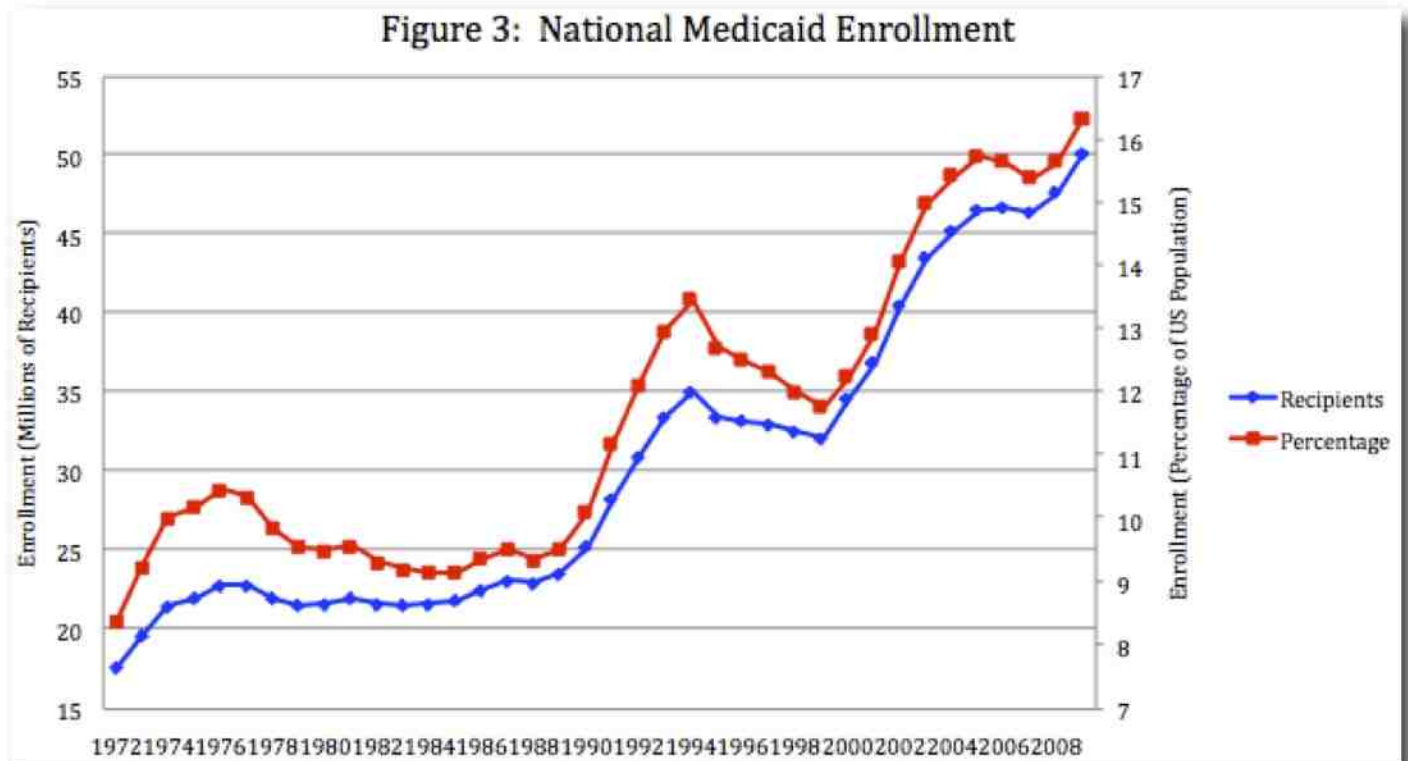
Figure 2 shows Medicaid spending as a share of GDP. It shows a similar pattern to that in Figure 1. Spending rose steadily from the beginning of the program until the mid 1980s to about 1% of GDP. Following the expansions of the late 1980s and early 1990s, Medicaid's share of GDP doubled to 2% by 1995. The expansions of the late 1990s continued to rise so that Medicaid spending was over 2.6% of GDP in 2009.

Medicaid spending does show some cyclicity. Figures 1 and 2 illustrate this with declines in spending during the strong economic times of the late 1990s and mid 2000s. However, the path of program spending is more of a decided upward trend rather than that of following the business cycle.

Figure 3 displays enrollment in the Medicaid program, both in total (on the left-hand scale) and as a percent of the U.S. population (the right-hand scale), from 1972 to 2009. After the program's inception,

enrollments grew to 20 million, comprising about 10% of the nation's population by 1985. The expansions of Medicaid subsequent to that pushed enrollments to over 30 million and to 13% of the population by 1995 and then to over 15%. Even prior to the current

recession, over 45 million people were enrolled, well over 15% of the population. Again, the business cycle affects enrollments, but the dominant effect is the strong upward trend.



“Medicaid spending does show some cyclicity...However, the path of program spending is more of a decided upward trend rather than that of following the business cycle.”

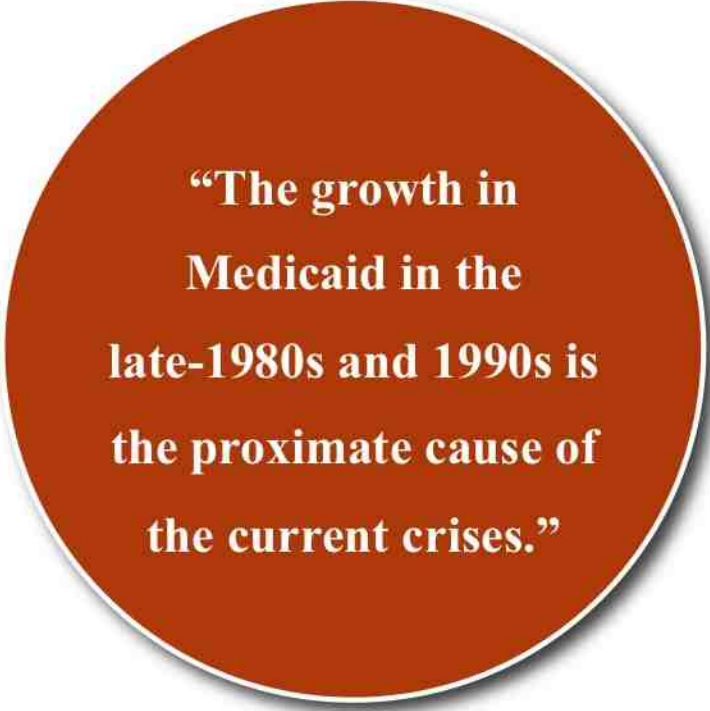
The growth in Medicaid in the late-1980s and 1990s is the proximate cause of the current crises. This growth was due largely to the expansion in the eligibility for pregnant women, children, and presumably to improve the health status of this population. Attainment of healthcare coverage for these groups is an admirable goal and it is not difficult to imagine circumstances where assistance for these persons is appropriate. However, it is always useful to inquire about the effectiveness of government programs in achieving their stated objectives. This is especially true of a program like Medicaid that has entailed such a large and growing commitment on the part of taxpayers. A number of studies indicate that Medicaid is disappointing in this regard.

The period of rapid expansion of Medicaid during the 1980s and 1990s has been studied extensively to determine its effects on coverage, medical services utilization, and health outcomes. During this time, the federal government enabled states to expand coverage to certain groups at specified thresholds above the poverty line, followed by mandates regarding coverage of these groups. Because expansions occurred in different states at different times, many studies examined what happened in states that did expand relative to those that did not, as well as the before-and-after differences within states. Several aspects of these studies are quite informative and relevant to our discussion.⁴

⁴ Many of the remarks in this section are discussed in more detail in Gruber (2000).

⁵ The most well known of this type of estimate is by Cutler and Gruber (1996) who found a 50 percent crowding out of private insurance. An update of this paper by Gruber and Simon (2007) found a 60 percent crowding out rate.

⁶ See Brown and Finkelstein (2008).



“The growth in Medicaid in the late-1980s and 1990s is the proximate cause of the current crises.”

One outcome of these expansions has been the “crowd out” of private insurance. The extension of Medicaid to families substantially above the poverty line has resulted in a large increase in the number of people covered by Medicaid, but also a large number who dropped private coverage to enroll. In fact, many estimates indicate that the latter effect is very large, e.g., for every 10 additional participants in Medicaid during this time period, 5 to 6 of those would have obtained private insurance if Medicaid was not available to them.⁵ Another recent study examining the long-term care aspect of Medicaid finds even larger crowding out of private insurance in that market; at least two-thirds of recipients would have otherwise obtained private long-term care insurance.⁶

While no public assistance program is immune from attracting participants that the program is not intended for, the size of the effect for Medicaid seems inordinately large. We suspect that much of the U.S. citizenry would be very dissatisfied with the expansion of a public support program where less than half of the additional participants are in the target population.

“While no public assistance program is immune from attracting participants that the program is not intended for, the size of the effect for Medicaid seems inordinately large.”

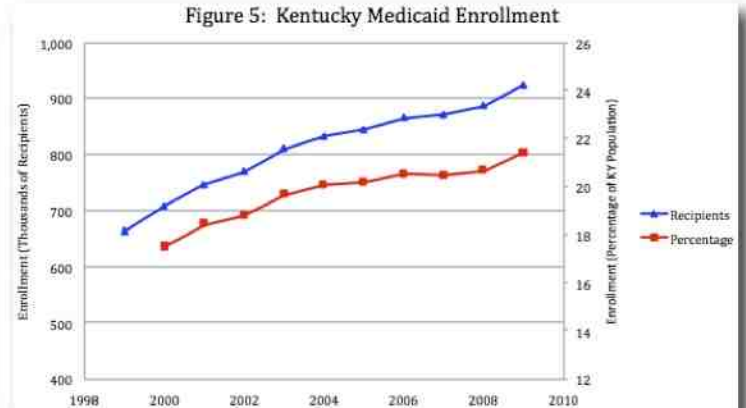
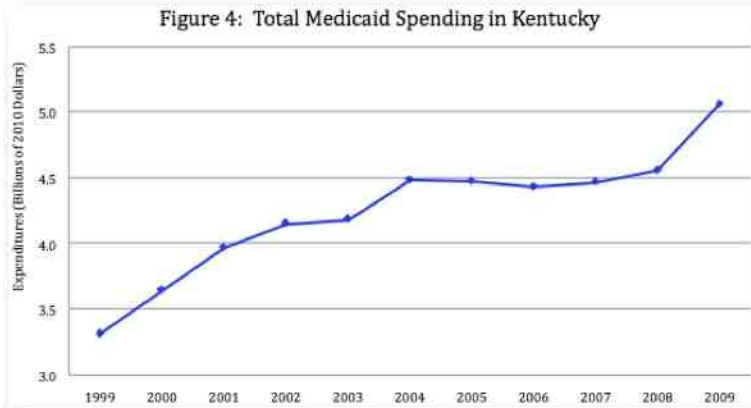
Perhaps equally important, such large crowd out effects are counter to reform that embraces market-based solutions – the type of reform we consider most meaningful and effective. This approach seeks to encourage competition within the private sector to provide good quality and inexpensive health insurance alternatives and which encourages healthcare consumers to shop for the coverage that best suits them. A program that induces people to pull away from private medical coverage is antithetical to this type of reform.

Studies of the Medicaid expansions of the 1980s and 1990s also examine their effects on healthcare utilization and health outcomes. These studies focus

on prenatal care, hospitalizations, use of preventative care for children, incidence of low birth weight, and infant mortality since the expansions dealt mostly with pregnant women and children. Several studies examine particular states regarding their pre- and post-Medicaid expansions and generally find no consistent effect of Medicaid on utilization or health outcomes. Other studies utilize a broader sample of states in addition to variation of coverage over time

and several find that the expansions raised utilization and health outcomes. However, the evidence suggests that these improvements are focused on the very poor who became eligible for Medicaid due to the late-1980s expansions. Later rounds of expansions reached into higher income groups who did not experience increased healthcare services utilization or improvement in the health outcomes measured by the studies.

These findings are consistent with the results regarding crowd out. Those individuals with somewhat higher incomes are likely to be the ones who forgo private insurance when they become eligible for Medicaid. Thus, they experience little change in healthcare use or in health status. Broad expansions are not targeted toward the truly needy, induce many people to drop private health insurance who subsequently experience no improvement in health status, and cost the taxpayer ever increasing amounts. Broad Medicaid expansion is ill-advised, especially in light of the good policy alternatives that exist.

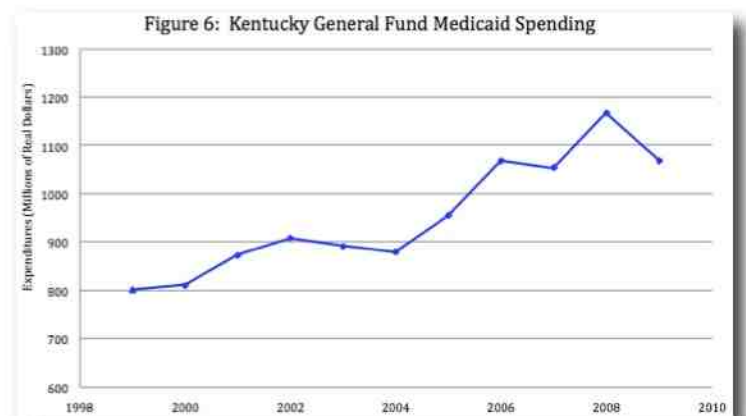


A. Recent Expenditure and Enrollment Trends

Figure 4 displays total real spending (federal and state) on Medicaid in Kentucky from 1999 to 2009. Real total spending rose substantially during 1999 to 2004, from \$3.3 billion to \$4.4 billion, and stayed at about the same level through 2007, due in part to a strong economy. It began rising again and during 2009 was over \$5 billion. During 1999 to 2009 this was a 54% increase and the number of Medicaid enrollees rose continuously during this time. Figure 5 graphs the number of Kentucky participants in the program, in total (right-hand scale) as well as a percent of the Commonwealth’s population (left-hand scale). Total enrollees rose from about 664,000 in 1999 to approximately 924,000 in 2009, a 39% increase. Enrollment rose during this time from 16.7% of the population to 21.4%. The latter figure is well above the percent of enrollees in the U.S. for 2009 of 16.3%. The upward trend in Kentucky is reflective of that for the entire U.S., also entailing

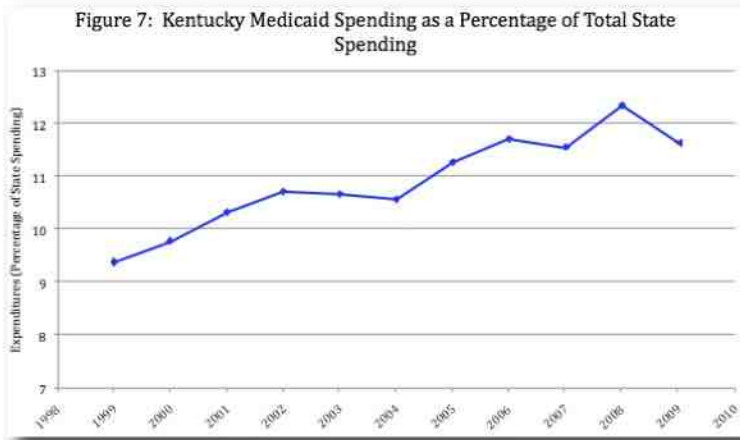
increased coverage of children in above-poverty line families and the crowding out of private insurance.

While Figure 4 shows the total of state and federal spending for Kentucky’s Medicaid recipients, Figure 6 presents data on the amount of state general fund spending on Kentucky’s Medicaid program from 1999 to 2009. This is the direct contribution Kentucky makes to Medicaid. With some exceptions, it rose fairly steadily over the past decade, from just over \$800 million to around \$1.1 billion, a 37% increase. The decline in 2009 was due to the federal government taking on a greater share of Medicaid costs.



MEDICAID IN KENTUCKY

Figure 7 presents these figures as a share of total general fund spending. From 1999 to 2008, this rose from a little over 9% of the general fund budget to over 12%, with a decline in 2009 due to the federal government taking a larger share of Medicaid spending.



B. Some Recent Policy Initiatives

Increases in Medicaid spending have been an issue for quite some time. Here, we discuss several recent policy initiatives by state government to deal with this problem.

In 2006, the Fletcher administration sought to make reforms to Kentucky's Medicaid program under the Deficit Reduction Act of 2005, which gave states greater flexibility to run their respective state programs. As a result, Kentucky created KyHealth Choices that divided the Commonwealth's Medicaid enrollees into four different systems with the goal of providing more individualized care for specific populations.⁷ Family Choices served children, Comprehensive Choices the elderly, Optimum Choices

the developmentally disabled and Global Choices the general population. Also, the plan allowed for some cost sharing and rewards for healthy behaviors. Around this time period, growth in both enrollment and spending in Kentucky's Medicaid slowed considerably. It is difficult to tell, however, how much of this slowing was due to a good economy and how much due to the KyHealth Choices program. With the economic recession beginning in 2008, Kentucky's Medicaid enrollment increased significantly, however.

After Congress passed the American Recovery and Reinvestment Act (ARRA) in 2009, Kentucky's share of Medicaid payments fell, with the federal government taking on a larger share. Technically speaking, this was an increase in Kentucky's Federal Medical Assistance Percentage (FMAP). This occurred for fiscal years 2009, 2010, and 2011, but the FMAP is slated to return to its usual level for fiscal year 2012. Due to the growth of the Medicaid program, this reduction in federal funds is expected to cause a budget shortfall. Medicaid dominated much of the 2011 legislative session as the Beshear administration predicted that the Commonwealth faced a \$100 million Medicaid budget deficit. After much legislative activity and line-item vetoes, the Commonwealth is slated to borrow \$166.5 million from the 2012 Medicaid budget to balance the current 2011 budget.⁸ Plans are to expand managed care to contain Medicaid costs and to make up for the shortfall in the fiscal year 2012.

⁷ For detail, see Cabinet for Health and Family Services (2006) <http://chfs.ky.gov/nr/rdonlyres/70ac8c04-bdef-4a64-ab06-45fee8285a04/0/1115waiver.pdf>.

⁸ Beth Musgrave and Jack Brammer, "House passes Senate budget fix after Beshear promises to veto spending cuts," Lexington Herald-Leader, March 24, 2011, <http://bluegrasspolitics.bloginky.com/2011/03/24/house-passes-senate-budget-fix-with-promises-from-beshear-that-he-would-veto-the-cuts/>.

Kentucky currently has a managed care plan for its Medicaid recipients in Jefferson and surrounding counties. This is the Passport Health Plan that has come under recent scrutiny. Interest in Passport seems to have been heightened due to the expectation of more utilization of managed care for the Medicaid program.

Passport was created in 1997 as part of Kentucky's Medicaid Demonstration Project amended waiver approved by the federal government in 1995. Passport became the only sole-source, non-competitive managed care provider in the country. The Cabinet for Health and Family Services pays Passport a monthly fee to coordinate care. Passport must maintain expenditures below the federal cost ceiling dictated by the Center for Medicare and Medicaid Services according to historical trends. This is termed budget neutrality. The plan has maintained budget neutrality every year except for two since its formation.

In recent years, charges of mismanagement were brought against the management of Passport, and in 2010 Kentucky's Auditor of Public Accounts examined the program. The audit concluded that there were a number of organizational problems and that there is no mechanism in place to determine the amount of savings that had occurred with use of Passport. Thus, while Passport expenditures normally were below the federal cost ceiling, the cost effectiveness compared to a fee-for-service has never been evaluated.⁹

⁹ The full report is at Auditor of Public Accounts (2010) http://www.auditor.ky.gov/Public/Audit_Reports/Archive/2010PassportHealthPlanreport.pdf.

C. Scenarios and Projections of Future Budgetary Commitments

While it is difficult to make precise predictions for future spending for Medicaid, this section makes some simple projections based on past and expected future trends.

Precise predictions of the future of Medicaid naturally depend on the future course of public policy in this regard. We consider only two aspects of this: Medicaid under its current form and with PPACA. Considering details on what might transpire under these scenarios – e.g., changes in reimbursement rates – are beyond the scope of this exercise.

(i) Medicaid in Its Current Form

We take a simple approach toward examining trends in three aspects of Medicaid spending considered for several groups: (1) the percent of the group's population who enroll in Medicaid; (2) the percent of enrollees who incur Medicaid expenses during the year, and; (3) the cost per year of each person who incurs expenses. These three ratios are considered separately

“Precise predictions of the future of Medicaid naturally depend on the future course of public policy in this regard.”

for several groups, and are intended to be non-controversial and cautious.¹⁰ The groups are children of various age groups; non-aged/disabled adults of all ages; the aged; the blind and disabled of all ages; and all other recipients.

The above ratios are computed for each of these groups for 2000 to 2009 and trends examined. Two major trends emerge. One is a result of the well-known increase in medical costs that resulted in a substantial trend in Medicaid expenditure per person utilizing care. Second is the rise in Medicaid recipients as a share of each of the population groups. This is particularly true of children recipients. Little trend occurred for the percent of enrollees who utilize medical care.

Regarding our first projection for the Medicaid program as it is now, we assume that costs per person utilizing care rises by 3.3% per year. This is in line with the annual average change for medical care costs assumed by the Office of the Actuary, Centers for Medicare and Medicaid Services.¹¹ Second, we assume that enrollment in Medicaid rises by 0.5% percent per year. Kentucky's enrollment rose much more rapidly during 2000 to 2009, rising by an annual rate of around 2.5% and higher for children and non-aged adults. However, much of this growth was likely due to the take up of Medicaid after the expansion in the

late 1990s. Such rapid growth is unlikely to continue. Our assumed 0.5% growth rate is conservatively low but is in line with forecasts of enrollment growth for the U.S.¹²

Figure 8 displays the findings for both total Medicaid spending in Kentucky (left-hand scale) and Kentucky's share of the spending (right-hand scale).¹³ The numbers for 2000 to 2009 are from the Medical Statistical Information System. For the years 2010 to 2012, we display budgeted expenditures from the Office of State Budget Director. Our projections are shown for 2013 to 2020.

There is a decided upward trend through the whole time period displayed, though the budgetary numbers for general fund spending show a temporary drop due to an increase in federal matching funds and overall spending is budgeted to fall presumably due to economic recovery. Total spending on Medicaid in Kentucky was \$5.07 billion in 2009 and is budgeted to rise to \$5.76 billion in 2012. Under our projection, this would rise to \$8.26 billion by 2020. This is a 63% increase from 2009 and a 43% increase from 2012.

Kentucky general fund spending on Medicaid in 2009 was \$1.07 billion and is budgeted to rise to \$1.27 billion in 2012. The latter figure is after subtraction of the \$166.5 million that the Beshear administration suggests will be saved by using managed care. With

¹⁰ This approach is similar to that of Gokhale (2011). A related approach is in Office of the Actuary (2010).

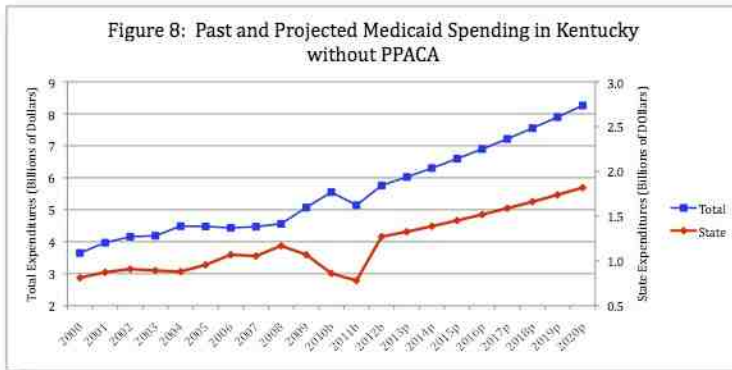
¹¹ See Foster (2010).

¹² Ibid.

¹³ For the projections, Kentucky's expenditures are computed as a share of total expenditures. Kentucky's share depends on the federal matching rate, which varies across programs. The federal rate was raised during 2009 to 2011. We assume it will return to its pre-recession average of 22%.

MEDICAID IN KENTUCKY

the projection, Kentucky's spending would rise to \$1.82 billion. This would be a 70% increase from 2009 and a 43% increase from 2012.



These projections are made under simple assumptions and do not take into account future economic and behavioral responses that might occur. They simply trace out what a continuation of current and plausible trends would be like. The projections are quite cautious with regard to increased medical costs and future enrollment growth and indeed show smaller increases than nationwide forecasts.¹⁴ Additionally, they do not include any increased administrative costs. Nevertheless, they show an unchecked continuation of increased budget pressure generated by the Medicaid program as currently structured.

(ii) Medicaid with PPACA

The above are the projections for Medicaid as the program currently stands. PPACA expands Medicaid by allowing a larger group of adults to qualify outside

the special categories of aged, blind, disabled, and medically needy. Presently, parents in Kentucky qualify for Medicaid for themselves if their income is less than 62% of the federal poverty level. PPACA allows all adults to qualify, whether parents or not, for incomes up to 133% of the poverty level.

This is slated to take effect in January 2014.

We make projections of the number of Kentuckians that will move onto Medicaid for 2014 and future years that are based on data from the 2009 American Community Survey (ACS). The ACS is a nationwide survey that has data on over 40,000 Kentuckians. From these data, we are able to compute the number of people in 2009 who would be eligible under the 2014 rules. A number of these people are uninsured, some have other government insurance (e.g., Tricare, VA), and many have private insurance. We assume that all the uninsured would go onto Medicaid as well as 55% of those with private insurance. The latter is consistent with previous estimates that Medicaid expansions crowd out 50 to 60 percent of private insurance.

“PPACA allows all adults to qualify, whether parents or not, for incomes up to 133% of the poverty level.

This is slated to take effect in January 2014.

¹⁴ See Foster (2010) for forecasts for the U.S.

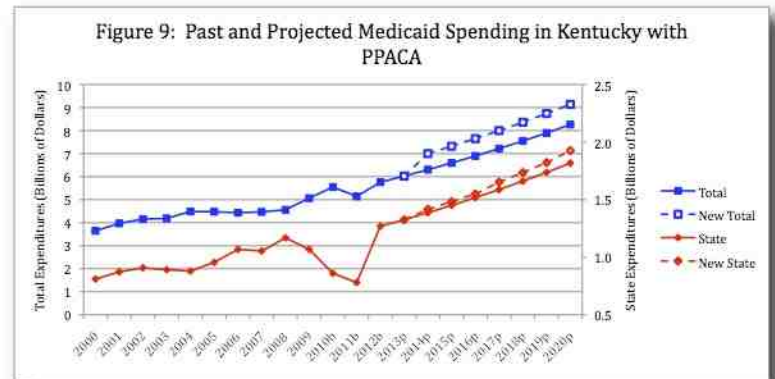
MEDICAID IN KENTUCKY

PPACA also mandates that individuals acquire health insurance. This is likely to induce those who are already eligible for Medicaid but failed to enroll to go ahead and do so. We use the 2009 ACS to estimate the number of adults who are currently eligible but not enrolled. We assume that this segment of the population will enroll under PPACA.

The assumptions underlying these projections, we believe, are quite cautious. There is reason to think that even more people will enroll in Medicaid under PPACA. The minimum coverage levels mandated by PPACA will raise the cost of some employer-provided insurance and induce them to drop coverage. Though there are penalties on employers for doing so, they are small relative to the cost of the insurance and the burden on low-income workers is eased by the mandate for subsidized health insurance for the latter. Thus, it is realistic to expect an even larger drop in private coverage than we assume, with those eligible for Medicaid moving to enroll.

By 2014, we project that the number of newly eligible Kentuckians to be about 236,000. Of these, our projection indicates that 111,650 will enroll and, for the previously eligible, 27,374 additional enrollees is projected.¹⁵ The cost per enrollee is assumed to be the same as that for adults in 2009, plus the medical cost inflation factor of 3.3% per year. For 2014, this is \$5,027 per enrollee. Total federal and state Medicaid expenditures for 2014 are projected to be \$699 million higher than without PPACA.

This is displayed in figure 9, along with projections through 2020. Projected total expenditures are graphed (left-hand scale) along with Kentucky general fund expenditures (right-hand scale). Solid lines represent the previous projection and dashed lines are the ones under PPACA. By 2020, total Medicaid spending is projected to have a further increase of \$877 million, rising to a total of \$9.14 billion. This represents an 80% increase from 2009 and a 59% increase from 2012.



Kentucky's spending also is projected to rise further as well. Kentucky would pay its usual share of the previously eligible people who enroll, but a smaller share of newly eligible enrollment. This share starts are zero and gradually increases to 10% by 2020. The projection indicates that another \$30 million of state expenditure would be added in 2014. By 2020, this projects to grow to \$108 million, pushing Kentucky's general fund spending on Medicaid to \$1.93 billion. This is 80% higher than in 2009 and 52% higher than 2012.

¹⁵ As in the previous projection, this assumes the one-half of one percent growth in this population group.

VI. MEDICAID REFORM

The foregoing discussion paints a troublesome picture of the Medicaid program, both in its basic structure and its prospects for future sustainability. While it is important to identify problems in public programs, it is equally important to develop solutions to these problems. We consider fundamental, significant reforms as well as less encompassing reforms. Some parts of the former and many of the latter have been tried in Kentucky and elsewhere.

A. Fundamental Reform

We regard the availability of good quality healthcare and health insurance at reasonable prices as an important goal. With the accomplishment of this goal, nearly everyone – even those with modest resources – can purchase their own healthcare and insurance. Enabling the attainment of low priced, good quality healthcare is perhaps the most effective way of assisting low-income people in this regard. However, even with this outcome, there will be cases and circumstances of true neediness by individuals where it is appropriate to provide public assistance. Thus, a second goal is to focus public assistance on the truly needy.

We recommend three major approaches to attaining these goals:

- **Fostering competition and choice in the private sector for healthcare services and health insurance.**
- **Provision of health insurance vouchers, based on income and health condition, for individuals to purchase their own health insurance plan.**

- **Block grants to states that provide funding to establish the program details most appropriate for their citizens.**

Though each point is listed separately, they work together and are mutually reinforcing.

(i) Fostering Competition and Choice

Competitive markets are remarkably effective at delivering a wide array of goods and services to consumers at affordable prices. This is true for the most mundane of goods and services (furniture, dinnerware, shoelaces, retail services) to many of life's essentials (food, clothing, housing) to the most sophisticated products (airplanes, high-definition TVs, consulting services). There are good reasons why this is so, though they are often taken for granted.

“We regard the availability of good quality healthcare and health insurance at reasonable prices as an important goal.”

Competition gives consumers choice. Firms that provide consumers with better products at lower prices are rewarded with more customers and profit. Investors seek these firms, which enables and encourages their growth. Moreover, competition stimulates efficiency by firms as well as entrepreneurial activity to discover new and better ways to provide goods and services. In short, enterprises which provide consumers with the best value are the ones that thrive. Additionally, consumers spend their own dollars and so have incentive not to waste their money but to buy goods and services which they truly value.

Though mistakes are made and the system is not perfect, it works well in getting vast quantities of a wide variety of goods produced and into the hands of consumers. The role of government in this regard is to provide clear rules of exchange (e.g., contract and property law) and prevent fraudulent activity so that mutually beneficial, voluntary exchange takes place between buyers and sellers. While healthcare is a unique good, so are each of the others in an economy, and the forces of competition and choice that generate good outcomes for the multitude of other goods would also work for healthcare. Unfortunately, many laws and regulations stand in the way.

Many states have certificate of need laws that require special permission to open new hospitals or medical facilities. Though the claim is that these laws limit unneeded or duplicative services, the result has been a restriction on competition and higher prices.

Insurance mandates and other regulation have required insurers to offer benefits in all plans that consumers may not want, with the result of higher insurance costs. States ought to consider policies that could enable more effective use of nurse practitioners and physicians assistants, which may lower costs while maintaining accountability and quality of care.¹⁶

Kentucky state government should examine carefully its laws and alter, modify, or abolish regulations that restrict competition among providers and insurers and limit or mandate choices by consumers. These short circuit the competitive process and prevent entrepreneurs from offering unique options for healthcare consumers.

Finally, the tax treatment of health insurance puts the individual health insurance market at a great disadvantage. Employer-provided health insurance is not subject to federal or state income tax, while income used to purchase individual health plans is taxed. This causes more private health insurance to be provided through employers and shrinks the market for individual policies tremendously. This is unfortunate, because individual plans have some distinct advantages. One is that individual plans are portable regardless of where the person works or if they lose their job. Another is that each person can purchase his/her own policy and tailor it to suit their specific needs. Also, a larger individual market would encourage insurers to focus more attention on and compete more heavily in this market.

¹⁶ For more discussion on these points, see Cogan, Hubbard, and Kessler (2005), Lenz, et. al. (2004), and Munding, et. al.

MEDICAID REFORM

Kentucky state government cannot directly change the disparate tax treatment of employer versus individual plans at the federal level, but it can do so regarding the state income tax. Also, it may consider adopting legislation like Utah. The Utah legislature has allowed employers to make contributions, free of both federal and state income tax, toward employee selected health insurance plans. The plans are held by the employees, not by the employers, so they are completely portable.¹⁷

“Kentucky state government should examine carefully its laws and alter, modify, or abolish regulations that restrict competition among providers and insurers and limit or mandate choices by consumers.”

The flourishing of competitive markets for healthcare provision and health insurance is likely to generate a variety of options and choices. For example, regarding insurance, we expect to find policies that suit the needs and budgets of a multiplicity of people, with differing levels of deductibles and co-pays, use of health savings accounts, utilizing managed care or fee-for-service, and varying in the composition of benefits. Additionally, an apparently common feature of individual plans is the guaranteed renewability at

group-average rates, so consumers do not face cancelled policies or premium hikes if they become seriously ill.¹⁸

The low prices and wide availability of goods and services enabled by competitive markets are available to all. In and of itself, this outcome assists the poor and helps alleviate poverty. Moreover, it helps the non-poor as well. Thus, this method of lessening the effects of poverty creates no conflict between income groups and does not generate any potentially contentious tax and expenditure program.

(ii) Health Insurance Vouchers

Though well-functioning, competitive markets for healthcare and health insurance will enable more low-income people to acquire healthcare for themselves, there are likely to be people in trying circumstances that the body politic would agree that public assistance for health needs is appropriate. The issue then becomes how to design the best program in this regard.

While no program is perfect, we advocate the use of health insurance vouchers. This also is known as premium support. The systems would work in the following way. Individuals qualify for a dollar amount of aid (premium support payment) to be used to pay premiums for a health insurance plan of their choosing. Those desiring a plan with premiums above the aid

¹⁷ See Girvan (2010) for a discussion.

¹⁸ For evidence on this, see Pauly and Lieberthal (2008).

MEDICAID REFORM

amount are free to add their own money to pay the higher premium. The support would be based on the income and family size of the recipient, as are most government assistance programs. The aid would decline as the recipient's income rises and falls to zero for a high enough income. Greater levels of support can be established for individuals with greater medical needs that entail significantly higher insurance premiums.

This type of program dovetails with policies that promote competition. A decided advantage of a voucher program is that recipients would be integrated into the competitive health insurance and healthcare markets as any other consumer. Providers and insurers would compete for their business just as other customers. Insurers set payments and reimbursement rates, so Medicaid's low reimbursement rates for physicians would no longer be a problem. Individuals can pick the insurance plan that best suits them and their own dollars are at stake on the margin; they spend their own money for more expensive plans so they have incentives to do so carefully. This may entail choosing plans with deductibles and co-pays, meaning individuals also are likely to be using their own dollars for routine care, limiting incentives for overuse. In general, the use of their own dollars induces healthcare users to become good shoppers and consumers.

While some might be concerned that recipients would be unwise shoppers, there is evidence on this to the contrary. Arkansas, New Jersey, and Florida were granted Medicaid waivers to institute the so-called

Cash and Counseling program for many disabled Medicaid recipients. These recipients are eligible for a variety of personal and household services. Under traditional Medicaid, the state contracts for these services that are performed for recipients. With the Cash and Counseling program, recipients are given a budget for these services and, with guidance from a counselor, can select the type, amount, and vendor of the services they purchase. In other words, they receive a voucher. Studies of this program indicate it has resulted in high recipient satisfaction, less fraud, and has saved on the use of expensive institutional care.¹⁹ Also, at least two other states Medicaid reform proposals – Utah and Washington – include trials of premium support programs.²⁰

An additional benefit of a competitive market for healthcare and health insurance is that those benefits accrue, in part, to taxpayers that fund the public insurance programs. Lower cost healthcare generated by competition and choice reduces the cost of the public assistance program.

Perhaps the most difficult problem confronted by policy makers for a voucher plan is the design of the plan itself. Levels of income must be set where one qualifies for different amounts of aid. Naturally, it is desirable to set the income and aid levels high enough to adequately reach the truly needy, but not so high as to attract people onto the program who can acquire healthcare for themselves. This is a fundamental problem that any income-support program faces and is not avoided here.

¹⁹ See, for example, Foster, et. al. (2003) and Frogue (2003).

²⁰ See Utah Department of Health (2011) and Stark (2011).

(iii) Block Grants

The use of block grants avoids some significant problems with the current Medicaid program as well as meshing with the other two aspects of fundamental reform. It is widely recognized by organizations across the ideological spectrum that the system of matching federal grants for Medicaid has been extensively “gamed” to the effect of over-expanding the program.²¹ When the federal government matches state spending on Medicaid, it increases the incentive for states to spend more since by doing so they receive more funds from the federal government. Additionally, some states have used tax and budget transfer schemes where hospitals pay taxes or transfer budget dollars to the state in exchange for higher Medicaid reimbursement rates, the latter of which is mostly paid by the federal government.

The basic point is that states do not have a strong incentive for careful budgeting when federal money pays for much of the spending. A simple way to address this problem is to establish a fixed, block grant from the federal government to states for Medicaid, somewhat similar to the model of welfare reform of the 1990s. While there are a number of details of each block grant to be determined, the basic principle is that states would be responsible for any expenditure beyond the grant amount. Incentives to game the system for more federal money disappear.²²

Within that block grant amount, states would have broad flexibility to design programs as they wish, with some constraints to the minimums that states may do. Giving states this flexibility enables them to design the program that suits them best. Our recommended approach is for states to foster competition in their healthcare and insurance markets – which are helpful reforms regardless of Medicaid – and to use the flexibility of the block grant to establish a system of health insurance vouchers. The appropriate voucher amount and how it varies with income will vary from state to state. Similarly, how the voucher may vary with the recipient’s current health condition is something for states to determine and is likely to vary across states.

There already has been a significant example of success with this type of reform in Rhode Island. Rhode Island received a Medicaid waiver in January 2009 to cap its federal assistance over a five-year period in exchange for flexibility in designing its Medicaid program. Though Rhode Island did not utilize insurance vouchers, it did introduce competition for Medicaid patients among managed care organizations, among other things. Remarkably, the state is on track to spend at least 20% below the spending cap.²³ Perhaps influenced by this success, the State of Washington recently enacted its HB 5596, which authorizes submitting Medicaid waivers for block grant federal funding and flexible redesign of its program.²⁴

²¹ See Cato Handbook for Policymakers (2009), Blase and Gray (2011), Holahan (2011), Domenici and Rivlin (2010), National Commission on Fiscal Responsibility and Reform (2010).

²² Others have suggested related ways to remove this incentive, including having either the state or federal government being responsible for certain programs in their entirety, or for 100% of marginal dollars. See Holahan (2011) and Domenici and Rivlin (2010).

²³ See Galen Institute (2010).

²⁴ Stark (2011) provides a summary.

B. Other Reforms

There are a number of other more modest reform proposals that states have tried, proposed, or discussed to control Medicaid expenditures and address some of the inherent problems with Medicaid.

Managed Care and Choice. The use of managed care is quite common for Medicaid recipients.²⁵ However, several states allow, or are proposing to allow, recipients to choose among managed care providers. Florida's Medicaid reform initiative, granted by waivers in 2005, does this for a selected set of counties. Rhode Island's does so for the entire state, and the State of Washington proposes to do likewise. Managed care by itself is often thought to be a way to reduce Medicaid spending. Choice by consumers, however, puts an element of competition into the mix that ought to provide at least some incentive for providers to be more efficient and improve services to recipients. Additionally, allowing recipients to make choices about their healthcare encourages them to make good choices.

Cost Sharing. This may entail charging small premiums for Medicaid, requiring deductibles, and charging some co-pays for services. Cost sharing is intended to see that recipients have some "skin in the game," meaning that they have some incentive to avoid unneeded healthcare utilization. Rhode Island's

plan has this, as do Washington's and Utah's proposals.

Health Savings Accounts (HSAs). This is very much related to cost sharing. Allowing Medicaid recipients a health savings account, or funding such an account, enables them to use these dollars to pay their cost sharing as well as other medical expenses. This is to provide incentive for careful use of healthcare since the recipient's own dollars are at stake. The state of Washington's proposal includes use of HSAs. Also, Indiana's Healthy Indiana Plan, a state-run healthcare program targeted at those ineligible for Medicaid, makes significant use of HSAs.²⁶

“Cost sharing is intended to see that recipients have some ‘skin in the game,’ meaning that they have some incentive to avoid unneeded healthcare utilization.”

²⁵ See Kaiser Family Foundation (2010).

²⁶ See Healthy Indiana Plan (2011).

Opt Out Option. Another potential reform worth noting is the option for Medicaid recipients to opt out of Medicaid for those recipients who are employed. If their employer agrees, the recipient can apply Medicaid funds toward buying into the employer-sponsored plan. This integrates the recipient into the mainstream of health insurance and healthcare. Florida utilizes this in its waiver plan and it is also in Washington's waiver proposal.

“Managed care by itself is often thought to be a way to reduce Medicaid spending. Choice by consumers, however, puts an element of competition into the mix that ought to provide at least some incentive for providers to be more efficient and improve services to recipients.”

Direct Healthy Behavior Rewards. Florida's waiver program identifies particular health improvement activities – e.g., smoking cessation programs, weight management programs – that participants are rewarded for. The rewards are in the form of funding for an account used for medical expenses such as non-prescription drugs. Naturally, this is to provide incentives for healthier behavior.

Each of these does have appropriate effects on incentives and helps limit some of the negative aspects of the Medicaid program design. Thus, they are likely to generate positive outcomes. However, our view is that the fundamental reform approach is superior. It is difficult for healthcare planners to anticipate the ways in which cost saving and improved, more efficient care might occur. This is likely to differ substantially across time, place, and circumstance. We can think of no better way to discover, utilize, and adapt efficient and effective healthcare than through open, competitive markets. By doing so, we tap into the experiences of millions of consumers and tens of thousands of providers with the incentives to determine what works best. While modest reforms make sense and may serve to help transition to more fundamental reform, it is the latter that should be the final goal.

Medicaid has been problematic for quite some time. Its expansive spending growth over the past 25 years has put increased pressure on state and federal budgets. Our projections for Kentucky, as well as others for the U.S., indicate that this pressure is expected to intensify and be exacerbated by the Medicaid expansion in PPACA. This is even more troublesome coming at a time of budget crisis throughout the nation. Moreover, the evidence from past expansions of Medicaid paints an unfortunate picture, where the many additional recipients would otherwise have had private insurance and, as a result, any positive health effects for recipients are minimal or absent, aside from the very poor. In short, Medicaid has failed to fulfill the goal of improved health for most of its recipients. This shortfall perhaps is not surprising given all of the perverse incentives built into the Medicaid system that encourage more spending, fail to reward efficiency and smart shopping, and discourage private insurance. Kentucky and the nation deserve much

better regarding serving the taxpayers and in crafting a program that assists the truly needy.

We maintain that fundamental reform in Medicaid and healthcare is the appropriate path to take, promoting competition in healthcare provision and health insurance, providing health insurance vouchers to the truly needy based on income and health status, and enabling states to establish their own specifics via block grant federal funds. Other reforms may be helpful, and Kentucky has and is expected to experiment with some of them. We argue that fundamental reform will be much more successful in attaining good outcomes, though this will require some level of cooperation from the federal government to implement the essential changes.

Figure 1: National Medicaid Spending

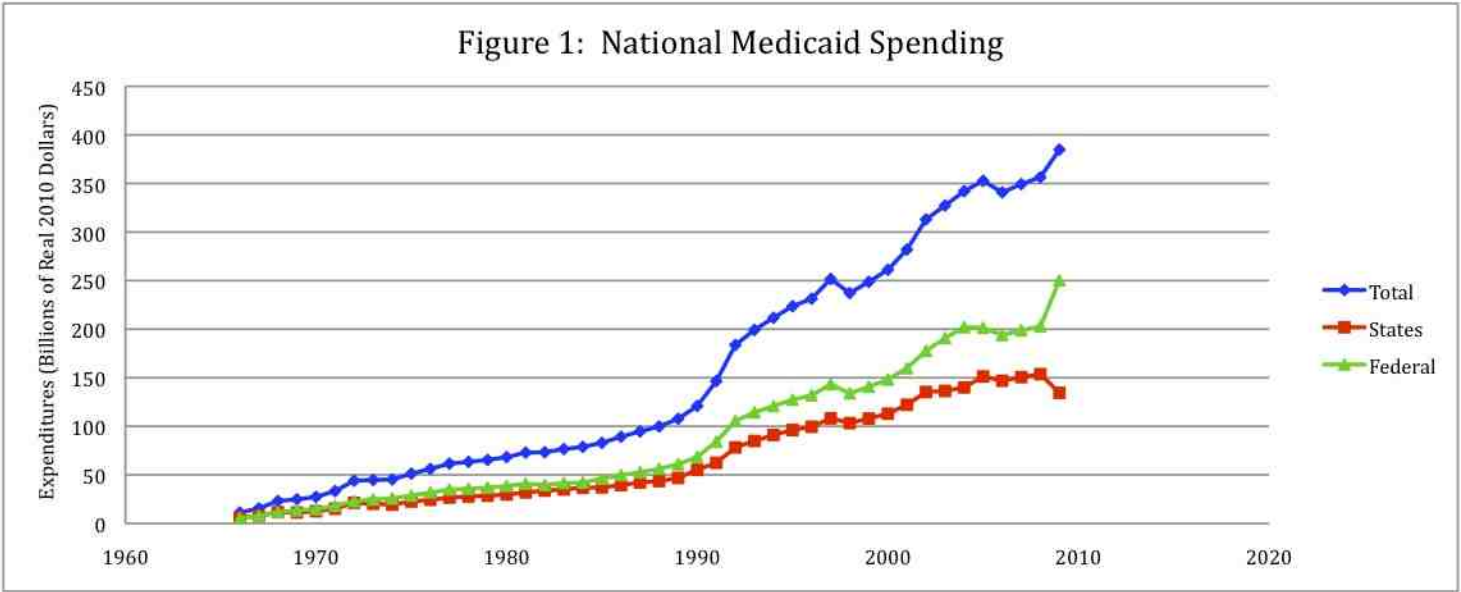


Figure 2: Medicaid Spending as a Percentage of GDP

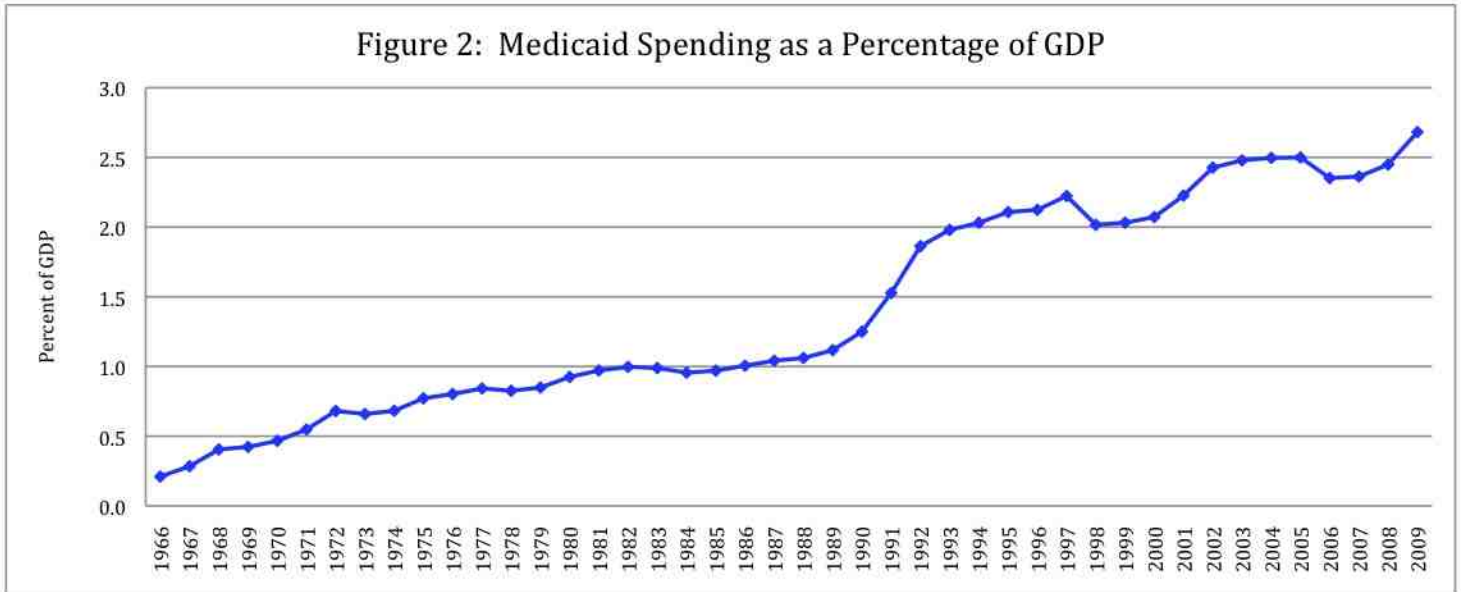


Figure 3: National Medicaid Enrollment

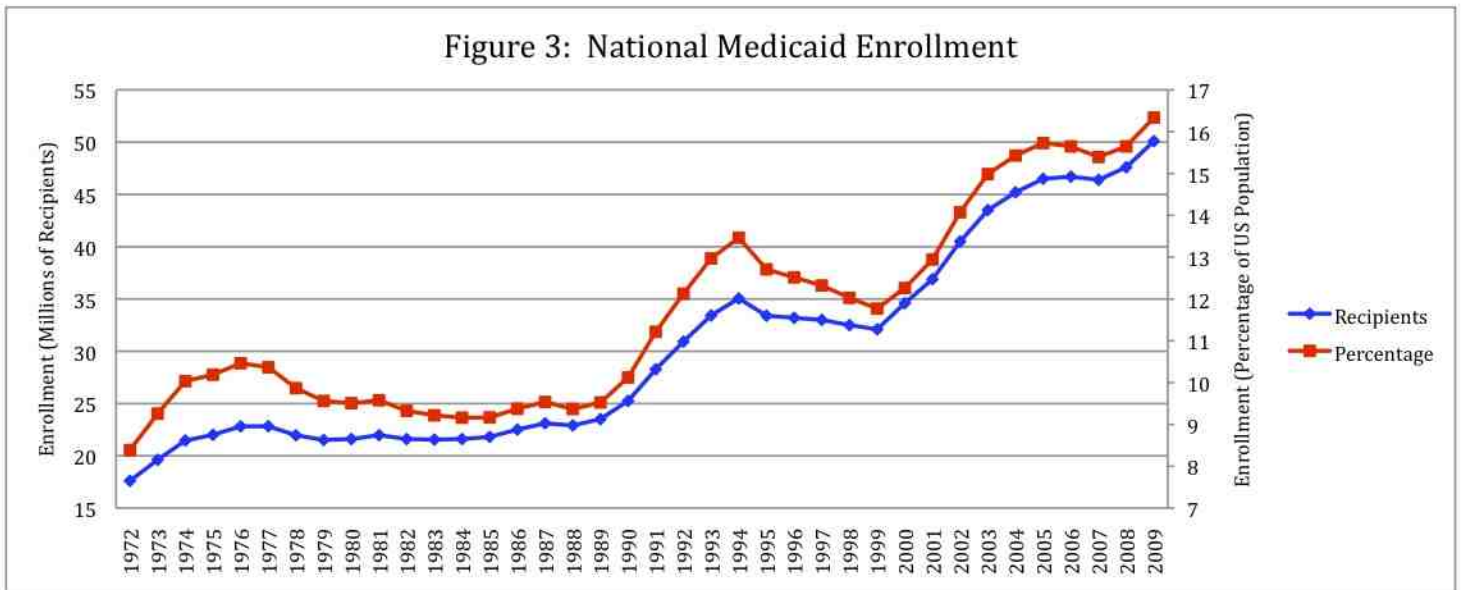


Figure 4: Total Medicaid Spending in Kentucky

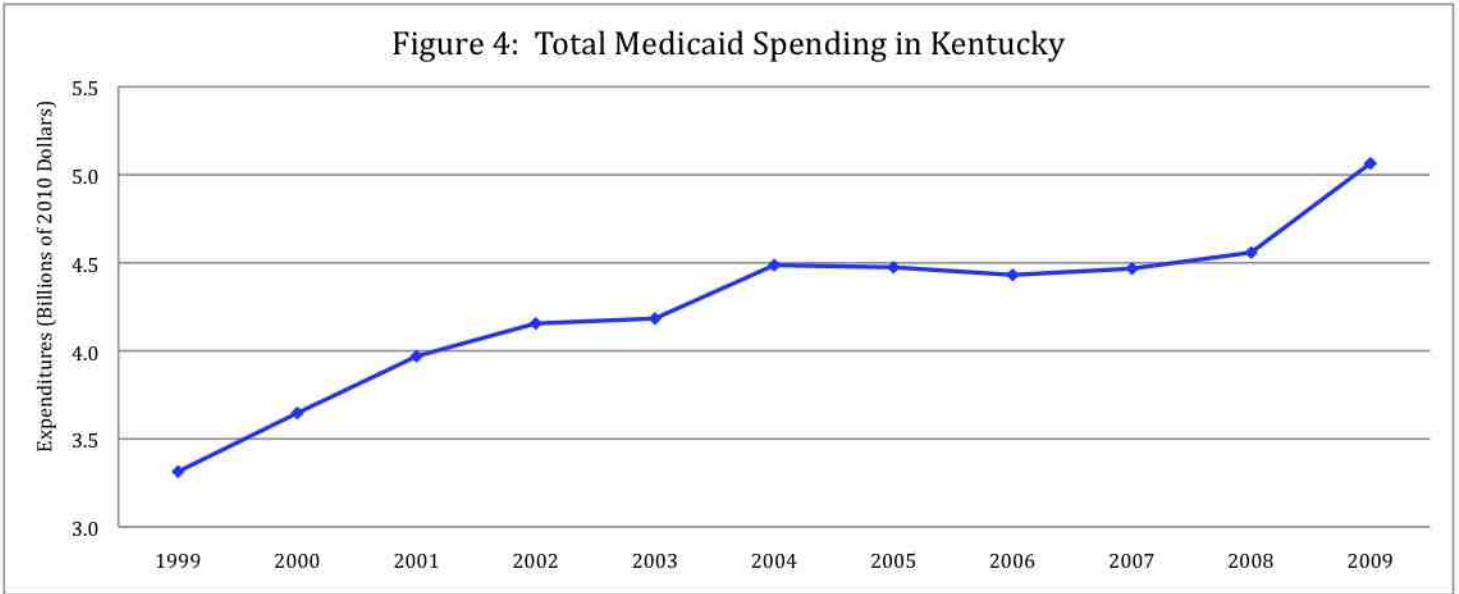


Figure 5: Kentucky Medicaid Enrollment

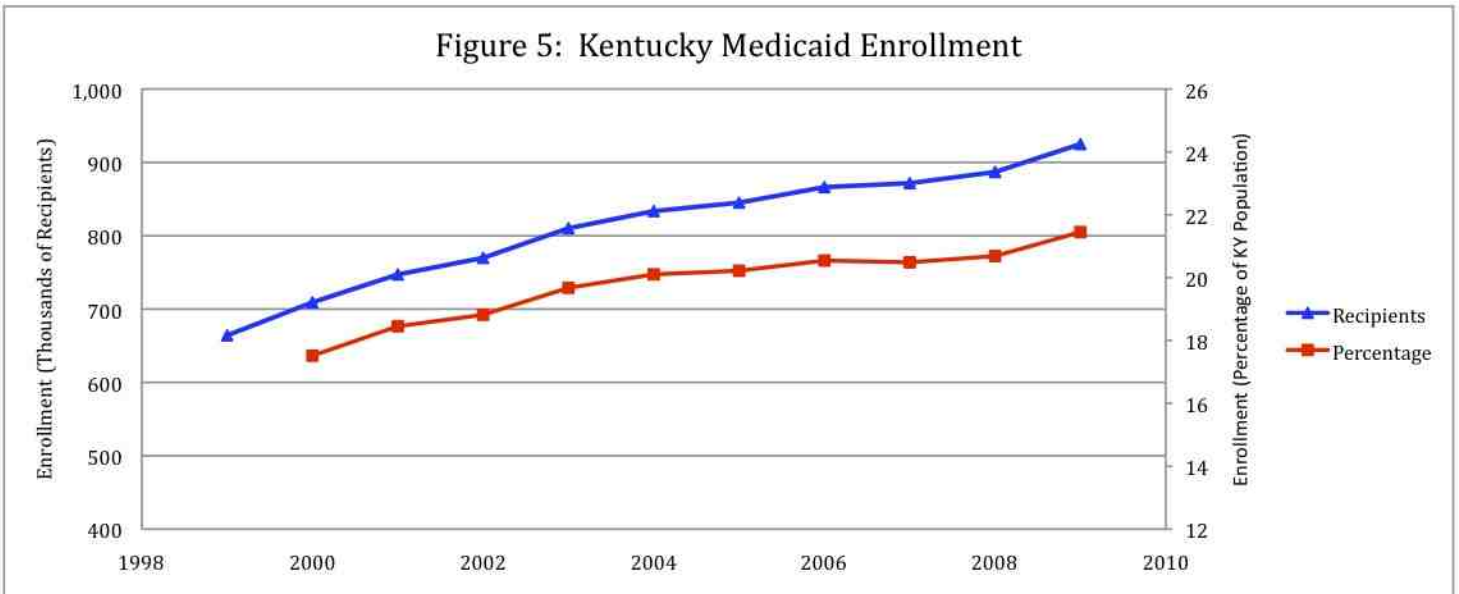


Figure 6: Kentucky General Fund Medicaid Spending

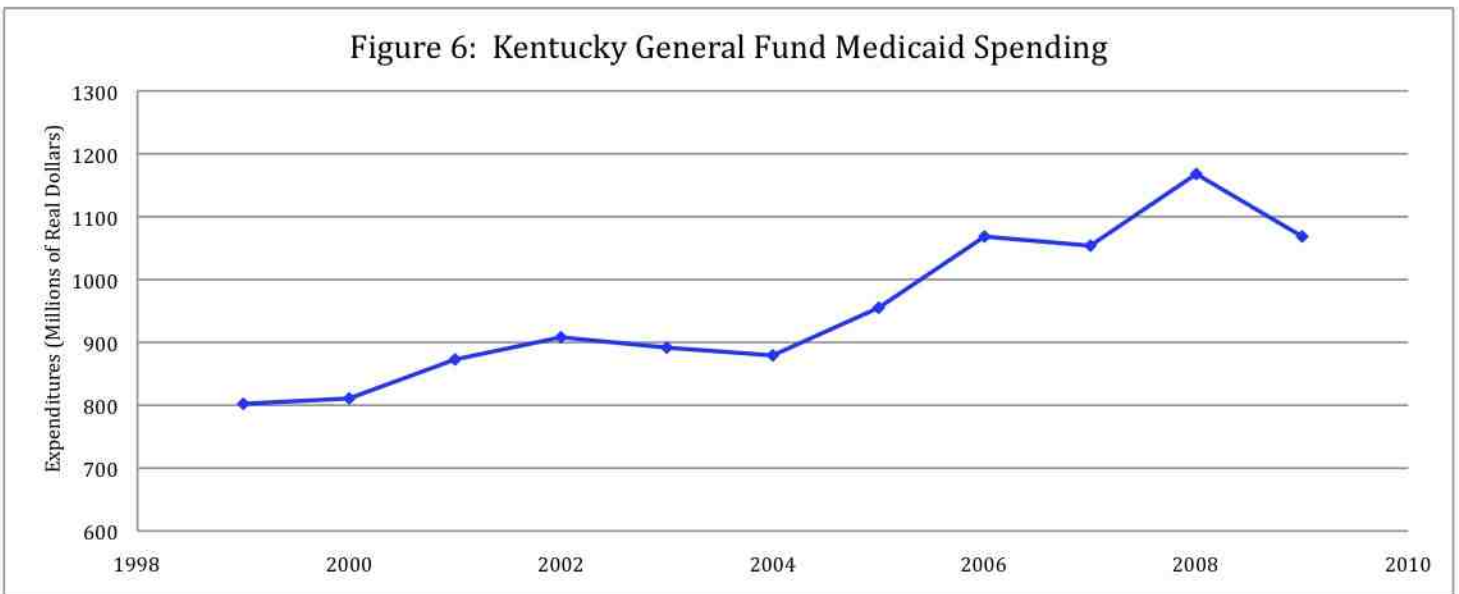


Figure 7: Kentucky Medicaid Spending as a Percentage of Total State Spending

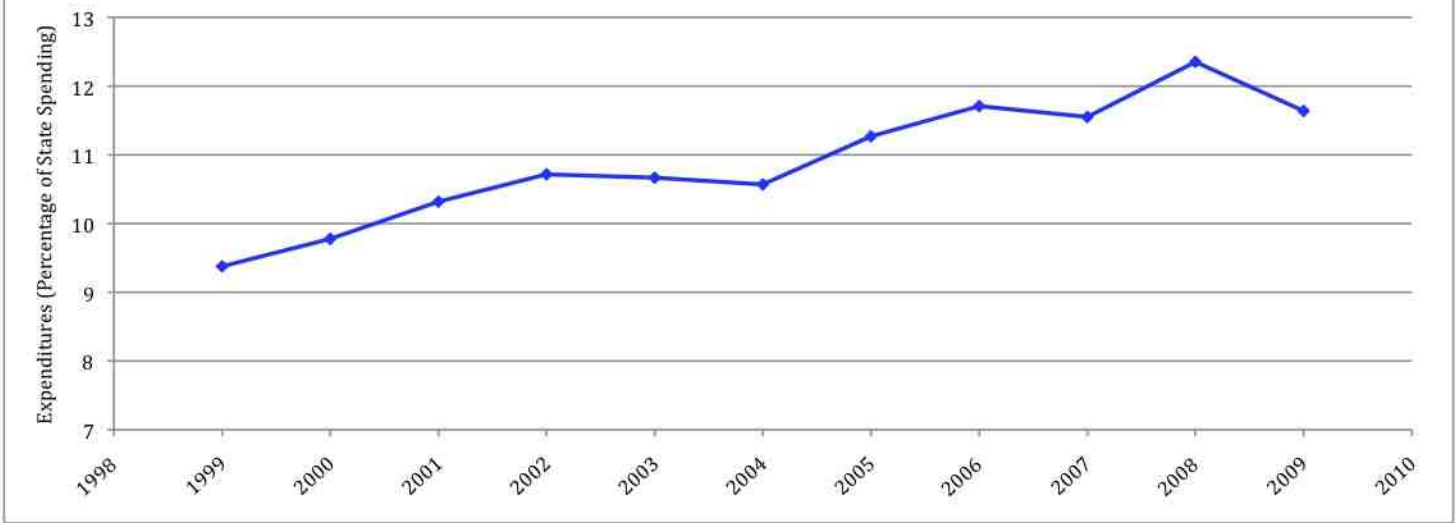


Figure 8: Past and Projected Medicaid Spending in Kentucky without PPACA

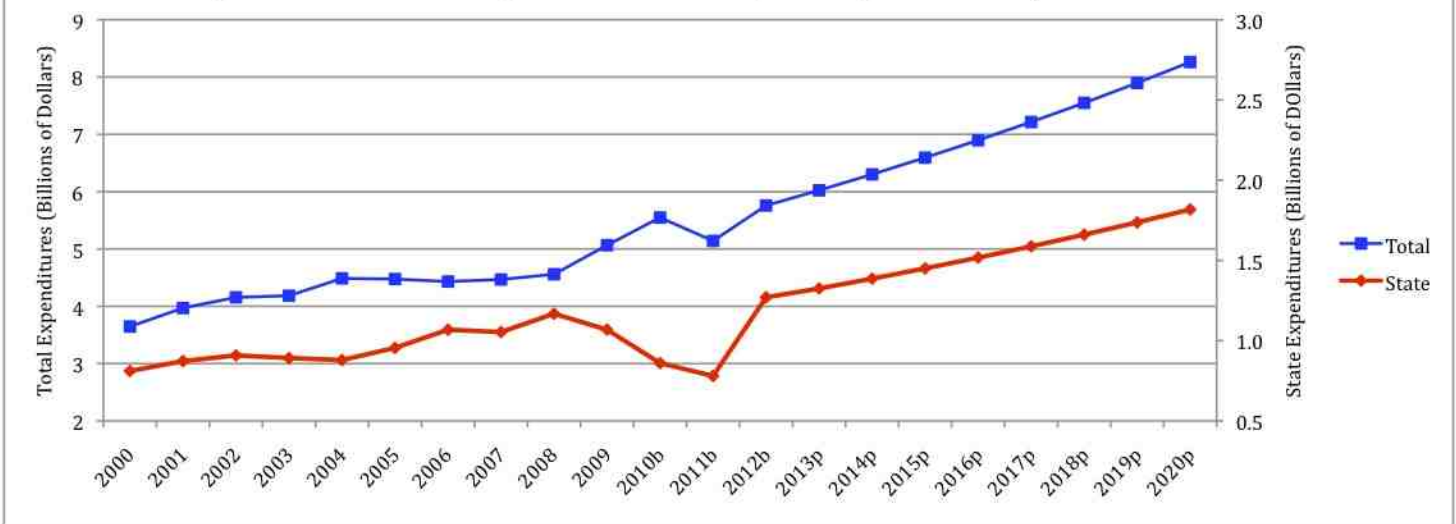
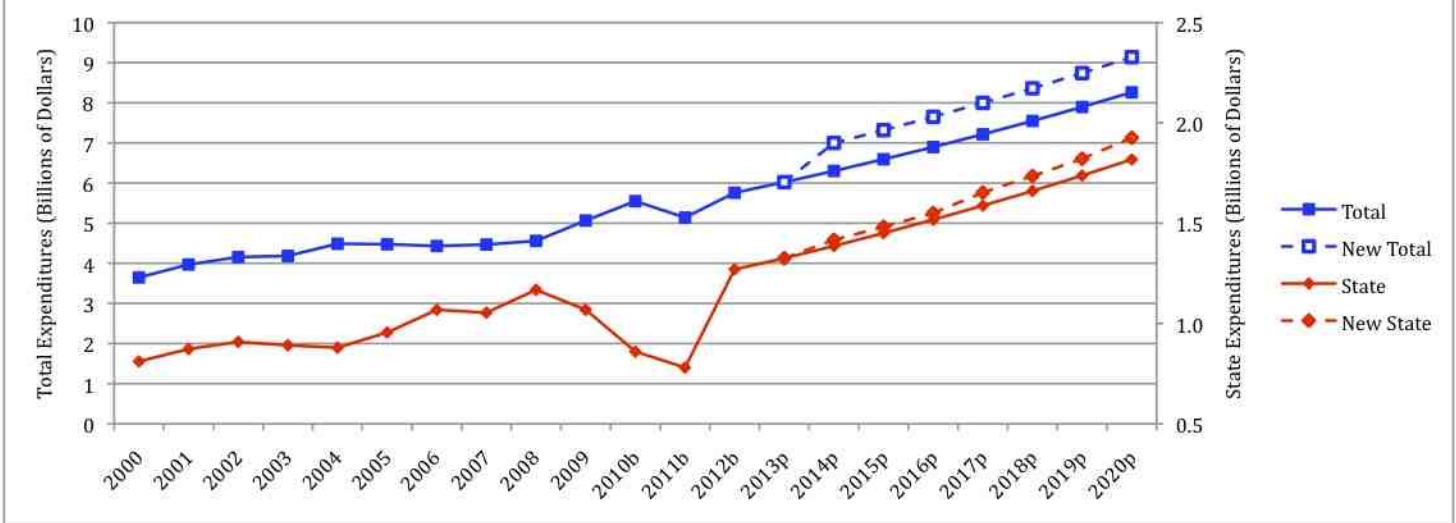


Figure 9: Past and Projected Medicaid Spending in Kentucky with PPACA



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