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House Committee on Energy & Commerce
Subcommittee on Health

STRENGTHENING MEDICAID

Improving Access to Care and Health Outcomes for the Poor

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INTRODUCTION

Medicaid, enacted in 1965 under Lyndon Johnson's "Great Society" initiative, was designed to provide health coverage to low-income Americans, especially those with incomes below the Federal Poverty Level. The Affordable Care Act expands eligibility for Medicaid to individuals with incomes below 138 percent of the Federal Poverty Level.

However, under the June 2012 U.S. Supreme Court opinion in *NFIB v. Sebelius*, states can choose whether or not to expand their Medicaid programs along the ACA's lines. As of January 2017, 31 states and the District of Columbia have chosen to participate.

Studies consistently show that patients on Medicaid have the worst health outcomes of any insurance program in America—far worse than those with private insurance and, strikingly, no better than those with no insurance at all. Access to a robust market for private coverage could significantly improve health outcomes for the poor, without increasing federal spending.[1,2]

MEDICAID'S POOR HEALTH OUTCOMES

A landmark study published in the *New England Journal of Medicine* compared health outcomes for Oregon residents who had won a lottery to enroll in that state's Medicaid program with demographically similar residents who had lost the lottery and remained uninsured.

After following these individuals for two years, the authors found that Medicaid "generated no significant improvement in measured physical outcomes" such as mortality, high blood pressure, high cholesterol, and diabetes.[3]

Other studies have found similar results. A University of Virginia study published in the *Annals of Surgery* examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.[4]

The authors divided their patient population by the type of insurance they held—private, Medicare, Medicaid, and uninsured—and adjusted the database to control for age, gender, income, geographic region, operation, and comorbid conditions. That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients are more likely to have ill health).

They then examined three measurements of surgical outcome quality: the rate of in-hospital mortality; average length of stay in the hospital (longer stays in the hospital are a marker of poorer outcomes); and total costs.

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[1] Roy A, Oregon Study: Medicaid 'Had No Significant Effect' On Health Outcomes vs. Being Uninsured. *Forbes*. 2013 May 2; http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/#4829d92173aa.

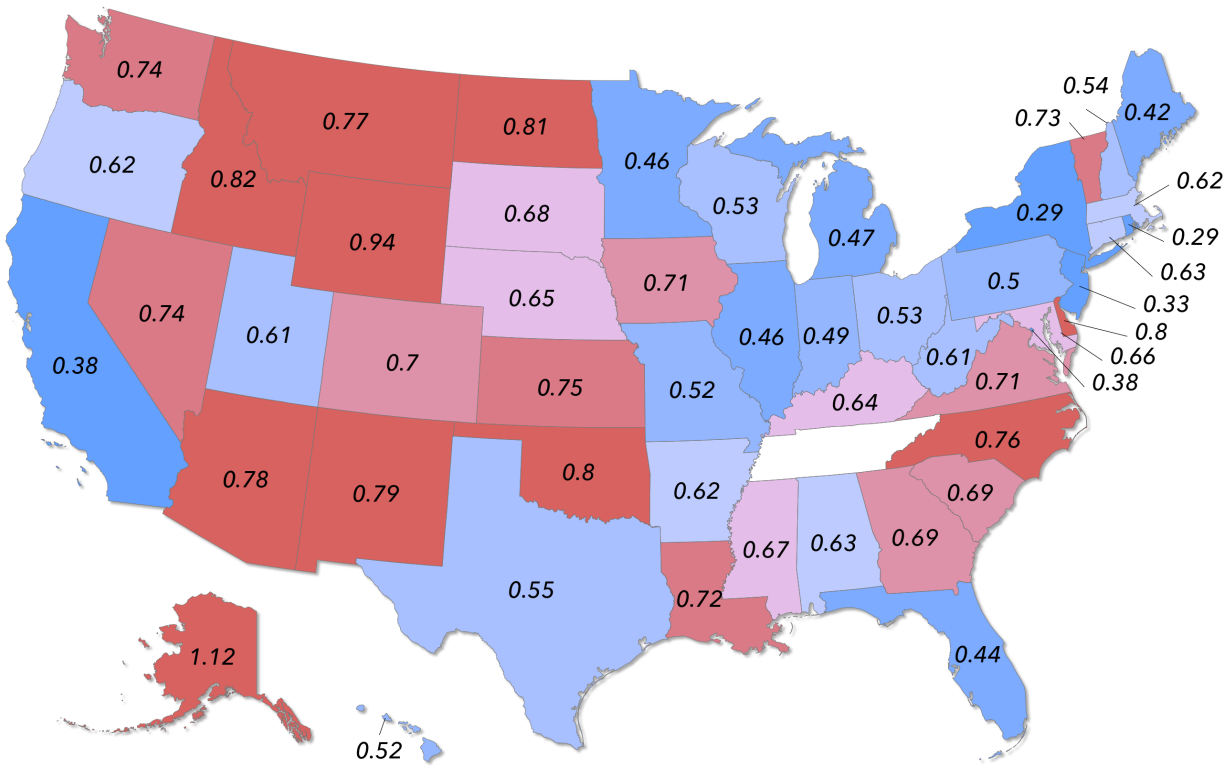
[2] Roy A, *How Medicaid Fails the Poor*. Encounter Books. 2013.

[3] Baicker K et al., The Oregon experiment—effects of Medicaid on clinical outcomes. *New England Journal of Medicine*. 2013 May 2; 368(18): 1713–22.

[4] LaPar DJ et al., Primary payer status affects mortality for major surgical operations. *Annals of Surgery*. 2010 Sep; 252(3): 544–51.

The in-hospital death rate for surgical patients with private insurance was 1.3 percent. Medicare, uninsured, and Medicaid patients were 54 percent, 74 percent, and 97 percent, respectively, more likely to die than those with private insurance.

Figure 1. Medicaid Reimbursement Rates for Primary Care, vs. Private Insurers, 2008



States have reduced Medicaid reimbursements to physicians in response to fiscal pressures. States that have been most aggressive in expanding eligibility and services within their Medicaid programs–like California, New York, and New Jersey–have faced the most pressure to reduce reimbursement rates to physicians and hospitals. *(Source: Urban Institute, FREOPP analysis)*

The average length of stay in the hospital was 7.38 days for those with private insurance; on an adjusted basis, those with Medicare stayed 19 percent longer; the uninsured stayed 5 percent shorter; and those with Medicaid stayed 42 percent longer.

Total costs per patient were $63,057 for private insurance; Medicare patients cost 10 percent more; uninsured patients 4 percent more; and Medicaid patients 26 percent more.

A University of Pennsylvania study published in *Cancer* found that, in patients undergoing surgery for colon cancer, the mortality rate was 2.8 percent for Medicaid patients, 2.2 percent for uninsured patients, and 0.9 percent for those with private insurance.[5] The rate of surgical complications was highest for Medicaid, at 26.7 percent, as compared with 24.5 percent for the uninsured and 21.2 percent for the privately insured.

A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease. Patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse on Medicaid than did the uninsured; Medicaid patients outperformed the uninsured if they had abdominal aortic aneurysms.[6]

A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 6 percent more likely to have late-stage prostate cancer at diagnosis (instead of earlier-stage, more treatable disease) than the uninsured; 31 percent more likely to have late-stage breast cancer; and 81 percent more likely to have late-stage melanoma.[7] Medicaid patients did outperform the uninsured on late-stage colon cancer (11 percent less likely to have late-stage cancer).

A University of Pittsburgh study of patients with throat cancer, published in *Cancer*, found that patients on Medicaid or without insurance were three times as likely to have advanced-stage throat cancer at the time of diagnosis, compared with those with private insurance. Those with Medicaid or without insurance lived on for a significantly shorter period than those with private insurance.[8]

A Johns Hopkins study of patients undergoing lung transplantation, published in the *Journal of Heart and Lung Transplantation*, found that Medicaid patients were 8.1 percent less likely to be alive ten years after their transplant operation, compared with those with private insurance and those without insurance. Medicaid was a statistically significant predictor of death three years after transplantation, even after controlling for other clinical factors. Overall, Medicaid patients faced a 29 percent greater risk of death.[9]

LOW REIMBURSEMENT RATES RESULT IN POOR PHYSICIAN ACCESS

Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians far below market rates to care for Medicaid beneficiaries.

In 2008, according to the Centers for Medicare and Medicaid Services, as shown in *Figure 1*, Medicaid paid physicians approximately 58 percent of what private insurers paid them for comparable services. These disparities have only increased over the ensuing decade.

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[5] Kelz RR et al., Morbidity and mortality of colorectal carcinoma surgery differs by insurance status. *Cancer*. 2004 Nov; 101(10): 2187–94.

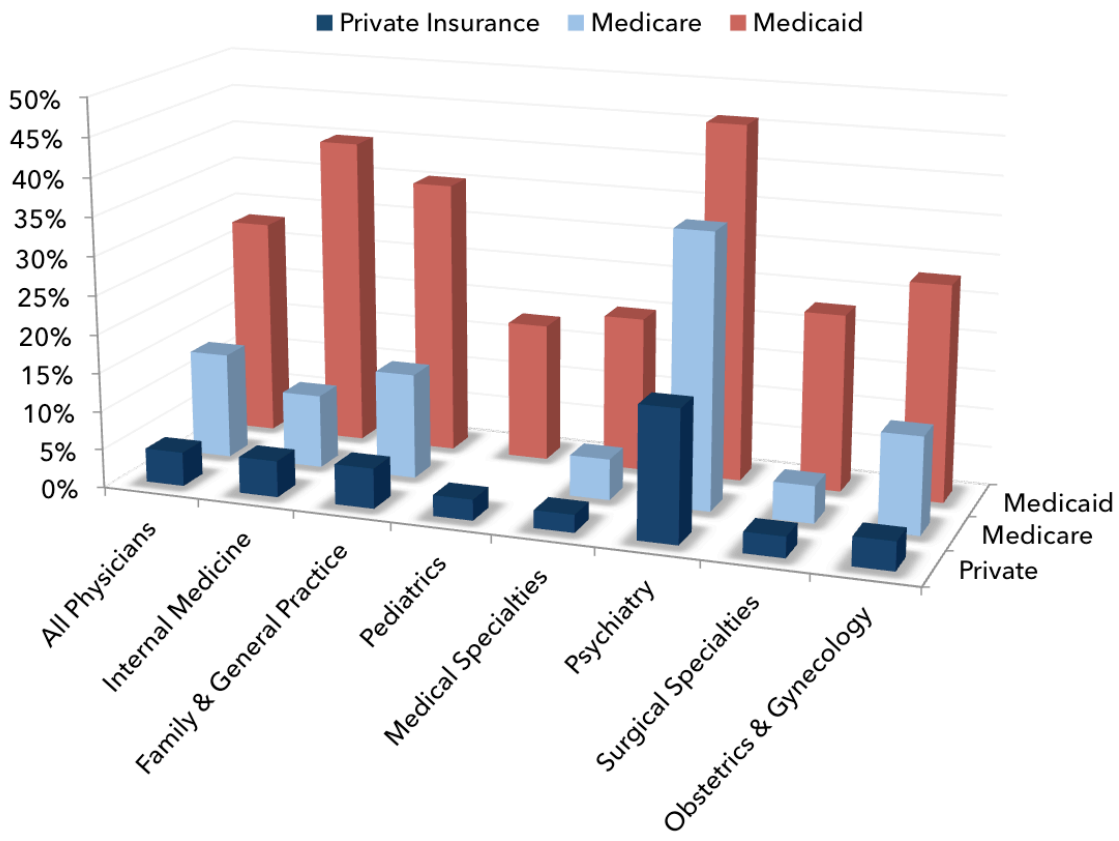
[6] Giacovelli JK et al., Insurance status predicts access to care and outcomes of vascular disease. *Journal of Vascular Surgery*. 2008 Oct; 48(4): 905–11

[7] Roetzheim RG et al., Effects of health insurance and race on early detection of cancer. *Journal of the National Cancer Institute*. 1999 Aug; 91(16): 1409–15.

[8] Kwok J et al., The impact of health insurance status on the survival of patients with head and neck cancer. *Cancer*. 2010 Jan; 116(2): 476–85.

[9] Allen JG et al., Insurance status is an independent predictor of long-term survival after lung transplantation in the United States. *Journal of Heart and Lung Transplantation*. 2011 Jan; 30(1): 45–53.

Figure 2. Proportion of Physicians Who Accept No New Patients, by Insurance Status, 2008

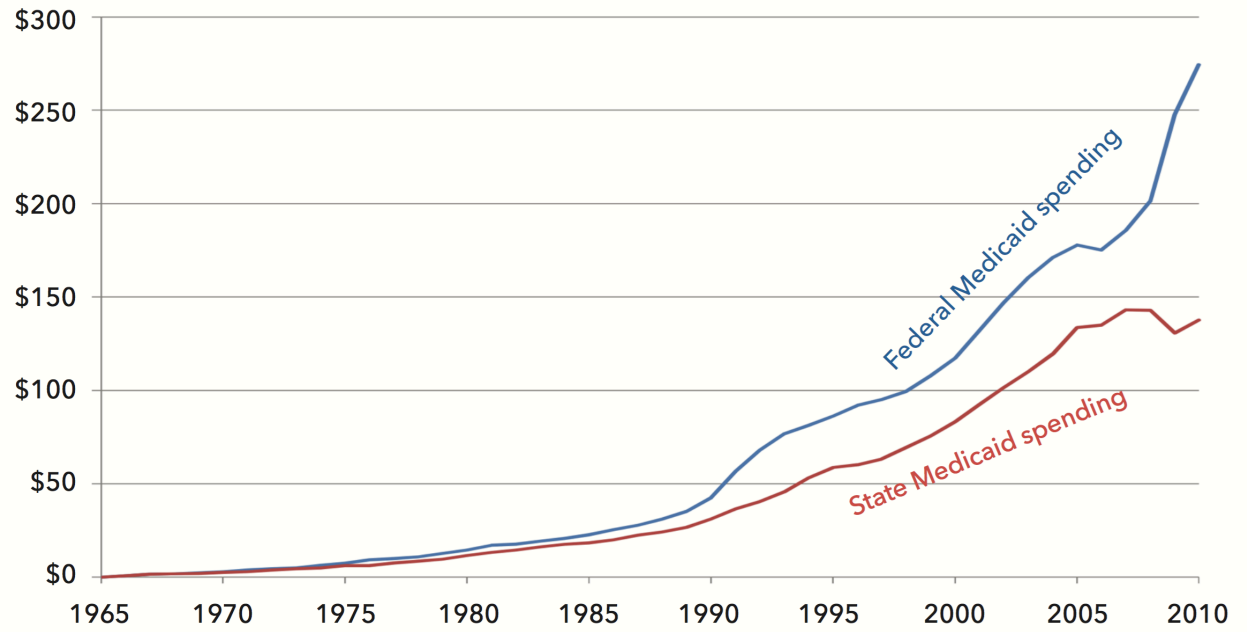


Fewer physicians are willing to see Medicaid and Medicare enrollees. The 2008 Health Tracking Physician Survey found that individuals with commercial health insurance enjoyed broad access to physicians, while those in Medicaid—and increasingly Medicare—do not. Reimbursement rates for Medicaid and Medicare, relative to private insurance, have fallen since 2008, suggesting that these access gaps have widened further. *(Source: Center for Studying Health System Change)*

Surprisingly, doctors fare even better treating the uninsured than they do caring for those on Medicaid.

A 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that, for nearly 60 percent of physicians, the average Medicaid fees were less than two-thirds of those paid by the uninsured, and that three-quarters of physicians receive lower fees for treating Medicaid patients than they do for treating the uninsured.[10]

Figure 3. Growth in Federal vs. State Spending on Medicaid, 1966-2009 (Billions)



States have gamed the system to attract more federal funds, while still reducing provider payments. During the first two decades of the Medicaid program (1965–85), state (*red*) and federal (*blue*) spending on Medicaid grew in concert. However, a federally mandated expansion of Medicaid eligibility in the 1980s drove states to deploy creative accounting techniques, such as provider and premium taxes, that could increase the proportion of Medicaid spending borne by the federal government. Ac- cording to the official government formula–the Federal Medical Assistance Percentage, or FMAP–the federal government is paying for 60 percent of the pre-ACA Medicaid program, while the states are paying 40 percent. In reality, however, the federal government is paying 67 percent, and the states 33 percent: a difference of more than $30 billion per year. *(Source: Bipartisan Policy Center, CMS)*

The difference in reimbursement rates does not capture the additional hassles involved in treating Medicaid patients—such as late payments from the government and excessive paperwork—relative to the uninsured, who pay in cash.

[10] Gruber J and Rodriguez D, How much uncompensated care do doctors provide? National Bureau of Economic Research. 2007 Nov; http://www.nber.org/papers/w13585.

Surveys consistently show that patients with private insurance have far superior access to care than those on Medicaid. As shown in *Figure 2*, The 2008 Health Tracking Physician Survey found that internists were 8.5 times as likely to refuse to accept any Medicaid patients, relative to those with private insurance.[11]

A 2011 study published in the *New England Journal of Medicine* found that individuals posing as mothers of children with serious medical conditions were denied an appointment 66 percent of the time if they said that their child was on Medicaid (or the related Children's Health Insurance Program), compared with 11 percent for private insurance—a ratio of 6 to 1.[12]

Among clinics that did accept both Medicaid/CHIP and privately insured children, the average wait time for an appointment was 42 days for Medicaid and 20 days for the privately insured. A related study, published by the same group in *Pediatrics*, found that 63.5 percent of Medicaid/CHIP beneficiaries were unable to get an appointment, compared with 4.6 percent of those with private insurance—a ratio of 14 to 1.[13]

These differences in access to physician care go very far in explaining why Medicaid patients suffer from poorer health outcomes than their counterparts with private insurance. It is likely that the poor outcomes of cancer patients on Medicaid are caused by the fact that those patients' cancers are not diagnosed early enough to receive effective treatment.

In addition, even when Medicaid patients gain access to care, the quality of that care is below average. A UCLA study published in the *Journal of the American Medical Association* found that those on Medicaid were far more likely to be treated in low-volume surgical centers than high-volume ones; high-volume surgical centers have consistently demonstrated superior outcomes.[14]

CREATIVE FINANCING GIMMICKS HAVE DISTENDED MEDICAID'S BUDGET

In turn, the principal driver of Medicaid's poor provider reimbursement rates is its dysfunctional fiscal structure. Medicaid is jointly funded by state governments and the federal government. Because neither party has full responsibility for the program, both parties have engaged in irresponsible behavior.

As Medicaid has grown over time, state budgets have come under increasing strain. States' Medicaid obligations now crowd out spending on other important responsibilities, such as education and public safety.

But it is mostly illegal for states to increase co-pays, deductibles, or premiums for Medicaid enrollees. Moving people off of the Medicaid rolls is highly controversial. And most attempts by state governments to enact minor programmatic changes must survive a lengthy waiver process with the U.S. Department of Health and Human Services.

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[11] Boukus E et al., A snapshot of U.S. physicians: key findings from the 2008 Health Tracking Physician Survey. Center for Studying Health System Change. 2009 Sep; http://www.hschange.com/CONTENT/1078/1078.pdf.
[12] Bisgaier J and Rhodes KV, Auditing access to specialty care for children with public insurance. *New England Journal of Medicine*. 2011 Jun; 364: 2324–33.
[13] Bisgaier J et al., Disparities in child access to emergency care for acute oral injury. *Pediatrics*. 2011 Jun; 127(6): e1428–35.
[14] Liu JH et al., Disparities in the utilization of high-volume hospitals for complex surgery. *Journal of the American Medical Association*. 2006 Oct; 296: 1973–80.

As a result, the path of least political resistance has been for states to reduce Medicaid's reimbursements to health care providers: paying hospitals and doctors less for the same level of service.

But states are not innocent victims of the federal government; they, too, have at times imprudently expanded their Medicaid programs by establishing creative financial schemes that transferred the costs of Medicaid expansions onto federal taxpayers.

As a result, when it comes to Medicaid, the interests of states and the federal government have diverged.

States have attempted to offload more costs onto the federal government, and the federal government has attempted to offload more costs onto the states.

As the Bipartisan Policy Center describes in its 2010 fiscal-reform proposal drafted by a panel co-chaired by Pete Domenici and Alice Rivlin, a federally mandated Medicaid expansion of Medicaid eligibility in the 1980s drove state governments to seek "every possible opportunity to amend the financing structure of state- and locally funded health care programs to cover additional services under Medicaid, and hence receive federal matching payments for these services."[15] In addition:

> States became highly creative in obtaining Medicaid for health services—such as visits to the school nurse by low-income children—that were previously fully funded with state and local resources. This search for federal dollars, referred to as "Medicaidization," brought dozens of new provider types and service categories under Medicaid.

States then created additional strategies to drive up federal funding.

In order to siphon additional Medicaid funding from federal taxpayers, they invented special Medicaid hospital taxes that increased state tax revenue, while also driving up the cost of care and thereby triggering additional federal Medicaid subsidies.

For example, a state hospital tax of $100 might be entirely passed on to the Medicaid program in the form of higher costs. If the federal government is required to fund 60 percent of a state's Medicaid program, that $100 tax results in a net gain to the state of $60 in extra federal Medicaid funding.

Similarly, states have also instituted sales and excise taxes on private health insurance premiums, and then contracted out their Medicaid programs to private insurers in order to collect premium taxes on the privately managed Medicaid plans.

These schemes did nothing to improve the quality of care offered to Medicaid beneficiaries, or increase reimbursement rates, but merely drove federal funds to state budgets, giving states the freedom to pursue other priorities with their own tax revenue.

The Bipartisan Policy Center observes that "by the early 1990s, the effective [federal contribution] for [Medicaid] hospital services exceeded 70 percent, far more than the national average matching rate of 56 percent that had prevailed throughout the first 25 years of the program" (*Figure 3*).

[15] Domenici PV et al., Restoring America's future: reviving the economy, cutting spending and debt, and creating a simple, pro-growth tax system. Bipartisan Policy Center. 2010 Nov; http://bipartisanpolicy.org/projects/domenici-rivlin-debt-reduction-task-force.

To this day, what BPC describes as a "shoving match" continues between state governments and the federal government, as each party strives to engage in ever more complex fiscal engineering, decreasing the stability of Medicaid's financial structure.

FOCUSING MEDICAID'S RESOURCES ON VULNERABLE POPULATIONS

Congress is considering three measures that could help states avoid the need to further cut provider reimbursement rates in the Medicaid program.

Focusing Medicaid subsidies on U.S. citizens and legal immigrants. In certain cases, federal law requires states to subsidize Medicaid-based coverage for those who have not yet documented that they legally reside in the U.S. To the degree that such individuals are not legally present in the U.S., the law forces states to spend scarce resources on those who are not eligible for Medicaid at the expense of those who are. Federal law should require proper documentation to enroll in Medicaid.

Shielding a spounse's assets from Medicaid eligibility tests. Medicaid is designed to provide financial assistance to those who cannot afford to provide health coverage for themselves. However, a loophole in federal law allows spouses of Medicaid long-term care enrollees to receive large annuities. Annuities, and all other assets, should count toward Medicaid eligibility thresholds.

Shielding lottery income from Medicaid eligibility tests. An individual who receives a $10 million lottery in one month is not eligible for Medicaid in that month, because his income is too high. But if his income goes to zero for the remainder of the year, he becomes eligible again for Medicaid due to his low monthly income. Congress should reconsider the treatment of lottery winnings and other lump-sum payments, so that Medicaid eligibility is reserved for those who are truly poor.

OFFERING PRIVATE INDIVIDUAL COVERAGE TO MEDICAID ENROLLEES

A system of means-tested, advanceable, and refundable tax credits to purchase private health insurance for the population currently eligible for Medicaid could address Medicaid's structural problems, and also substantially increase the quality of health coverage currently available to those on Medicaid.

Such tax credits are contemplated by many of the proposals to replace the Affordable Care Act, including the Patient CARE Act proposed by Senators Orrin Hatch and Richard Burr, former Sen. Tom Coburn, and Rep. Fred Upton, former Chairman of the House Energy & Commerce Committee. The Affordable Care Act itself deploys means-tested tax credits to subsidize coverage to those whose incomes are higher than Medicaid's eligibility thresholds.

FREOPP's health-reform proposal, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, proposes gradually migrating the entire Medicaid acute-care population onto a reformed individual market in which the subsidies now expended for Medicaid acute-care coverage are converted into premium assistance tax credits and health savings account deposits.[16] (For the purposes of simplicity, when this

[16] Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; https://drive.google.com/file/d/0B4VpAFwBu2fUYk5aV3Rud3NsUTg/view.

document refers to "Medicaid" it is referring to both the adult Medicaid program and the related CHIP.)

Under the FREOPP proposal, called the Universal Tax Credit Plan, the premium and cost-sharing subsidies for private acute-care coverage that are now available to those with incomes between 100 and 138 percent of the Federal Poverty Level, under the ACA, would under the Universal Tax Credit Plan be also available to all those with incomes below the poverty line.

By default, Medicaid acute-care enrollees would be gradually migrated onto the benchmark individual market plan in their states. Those who wished to remain in Medicaid, and not migrate onto the individual market, could opt out and remain in the legacy Medicaid program until January 1, 2027.

Another important problem facing the Medicaid population is the problem of churn between different types of insurance coverage. Poor individuals tend to have highly volatile incomes, leading to eligibility for different health insurance programs from month to month. This can end up disrupting relationships between patients and doctors, as different health plans offer different physician networks. By migrating Medicaid-eligible individuals into the reformed individual market, the Universal Tax Credit Plan would considerably mitigate the problem of churn.

States fund, on average, approximately 40 percent of the traditional Medicaid program; the federal government funds the remainder. However, the Affordable Care Act's insurance exchanges are entirely funded by the federal government. Hence, migrating the Medicaid acute-care population into the individual market, over a ten-year period, would increase federal funding responsibilities by approximately $1.2 trillion, and reduce state spending by a corresponding amount, excluding the impact of higher per-member costs with individual coverage (accounted for elsewhere in the Plan), and the fiscal offsets described below:

1. Returning responsibility for long-term care to the states

Under the plan, states that agree to transfer their Medicaid acute-care populations into the reformed individual market would be required, over time, to take over full funding and administrative responsibility for the Medicaid long-term care program.

This would operate, in effect, like a block grant from the federal government to the states, with two important differences: most states would eventually be 100 percent responsible for funding their long-term care programs; and they would be required to fund the program at levels that were no less than what the Centers for Medicare and Medicaid Services would have projected as the annual costs of the long-term care program through 2036 (i.e., a "maintenance of effort" requirement).

By requiring states to fund their long-term care programs at existing levels, but increasing their administrative flexibility, states could do much more than Medicaid currently allows. For example, they could assist beneficiaries with capital expenditures, such as increasing the accessibility of their homes to wheelchairs. Giving beneficiaries the tools they need to remain in their homes, instead of in long-term care facilities, will improve the quality of their lives while also optimizing program expenditures.

One significant advantage of cleaning up Medicaid's lines of responsibility is that it would substantially improve states' authority over their Medicaid-eligible populations. While the Universal Tax Credit Plan assigns to the federal government the financial responsibility of funding acute-care insurance for this cohort, state governments would have the authority to regulate the private health insurance plans that individuals would purchase on the reformed individual market.

This feature, combined with states' full authority over the long-term care program, would end the "1115 Waiver" system, in which state governments must ask federal permission, and wait years, to implement even trivial Medicaid reforms.

As John Holahan of the Urban Institute has pointed out, moving financial responsibility for Medicaid long-term care to the states will affect different states differently, depending on the size and scale of their long-term care populations.[17] Under a swap, a minority of states would end up as fiscal "losers," with a total net loss amongst them of $4.5 billion a year in 2011 dollars. These disparities can be managed through a gradual transition in which states with large long-term care populations receive supplemental grants from the federal government.[18]

In sum, the Medicaid swap and related offsets below would be designed in such a way so as to be modestly fiscally advantageous to every state government, relative to the federal government, in order to encourage states' participation.

2. Prohibition of state Medicaid provider taxes

The report published in 2010 by President Obama's National Commission on Fiscal Responsibility and Reform—popularly known as Simpson-Bowles—recommends "asking states to take responsibility for more of Medicaid's administrative costs by eliminating Medicaid payments for administrative costs that are duplicative of funds originally included in the Temporary Assistance for Needy Families (TANF) block grants."[19] We estimate that doing this would reduce federal spending by $3 billion between 2017 and 2026.

Importantly, the Simpson-Bowles report took on the issue of creative financing, noting that "many states finance a portion of their Medicaid spending by imposing taxes on the very same health care providers who are paid by the Medicaid program, increasing payments to those providers by the same amount and then using that additional 'spending' to increase their federal match. We recommend restricting and eventually eliminating this practice."

3. Sales and excise tax exemption for subsidized health insurance

An important driver of inflated health insurance premiums in the United States is state-based sales taxes and premium taxes. These taxes are passed onto consumers in the form of higher premiums, and passed onto taxpayers in the form of larger federal and state subsidies for health insurance premiums.

Take the example of an employer-based family health insurance plan costing $15,000 per year. Ohio, for instance, imposes a 5.5 percent sales tax and a 1 percent premium tax, amounting to an additional $975 per family. If that family is in the 25 percent federal tax bracket, and is liable for 15.3 percent in payroll taxes, these state taxes also result in $393 in lost revenue to the federal government. In other words, federal taxpayers are subsidizing Maryland's sales and premium taxes.

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[17] Holahan J, Restructuring Medicaid through a swap: an alternative to a block grant. Urban Institute. 2011 Apr; http://www.urban.org/UploadedPDF/412327-restructuring-medicaid-through-swap.pdf.

[18] Holahan argues for a different, somewhat more complex, swap, under which: (1) acute-care and dual-eligible Medicaid spending would be transferred fully to the federal government; (2) long-term care spending would shift to state funding supplemented by a federal closed-end matching grant; (3) Medicaid disproportionate share hospital payments would be eliminated or greatly reduced; (4) state "claw-back" funding for non-dual-eligible acute-care Medicaid where needed as a fiscal offset. Holahan does not propose migrating the acute-care Medicaid population onto the ACA exchanges.

[19] Simpson AK et al., The Moment of Truth. The National Commission on Fiscal Responsibility and Reform. 2010 Dec; http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

The problem is even worse in states that contract with private managed-care companies to administer their Medicaid programs. A $15,000 Medicaid plan, thereby subject to $975 in sales and premium taxes, might be 60 percent subsidized by the federal government, leading to $585 in additional federal spending.

The state government, by contrast, makes money on this deal: $975 in additional tax revenue, for $390 in additional state Medicaid spending, for a net gain of $585. In effect, the tax gimmick allows states to tax the citizens of other states. For every dollar of taxes that a state levies on its Medicaid program, 60 cents are levied upon the taxpayers of other states. It is not difficult to see why many state-based politicians have found this maneuver appealing.

Furthermore, these premium taxes give states a perverse incentive to mismanage their Medicaid programs, by making commitments they cannot sustain over time. In order to rectify this problem, the Universal Tax Credit Plan renders all federally subsidized health insurance plans—from Medicare, Medicaid, CHIP, individual tax credits, and employers—as exempt from state and local sales and premium taxes.

We estimate that the gross federal deficit-reducing effect of this change could exceed $100 billion in 2019, though it would be more than offset under the Plan by decreased state spending on the Medicaid acute-care population.

HARMONIZING FEDERAL ASSISTANCE FOR THE DISABLED

The federal government provides assistance to the disabled through the Medicaid and Medicare programs. Under the Universal Tax Credit Plan, Medicaid's long-term care for the disabled would be transitioned fully to the states, while Medicaid's acute-care coverage for the disabled would become entirely a federal responsibility.

The Universal Tax Credit Plan would take into account the special needs of the disabled population by consolidating acute-care coverage for the disabled in Medicare with the federal government's newly expanded responsibilities for acute care for the disabled Medicaid population.

The Plan would create a bipartisan commission to consider and enact reforms of this consolidated acute-care program for the disabled, in order to achieve the following goals:

Ensure that federal resources are focused on the truly disabled. This involves reexamining Reagan-era reforms that rolled back the use of objective health criteria in evaluating eligibility for disability coverage.[20]

Address the currently uninsured disabled population. The commission would examine the broader suite of eligibility criteria to see if there are gaps in the disabled population for whom assistance is warranted.

Harmonize asset limitations. Under Medicaid, many states require a disabled individual to have very low amounts of assets—under $2,000, for example—in order to gain certain types of disability coverage. However, Medicare does not have asset limits. As a result, low-income individuals have far stricter asset requirements than high-income individuals for

[20] Roy ASA, How Americans game the $200 billion-a-year 'disability-industrial complex.' *Forbes*. 2013 Apr 8; http://www.forbes.com/sites/theapothecary/2013/ 04/08/how-americans-game-the-200-billion-a-year-disability-industrial-complex.

federal disability coverage. These asset limits should be harmonized across the federally assisted population.

Rationalize the relationship between cash aid and health coverage. It may be worthwhile to convert some of the cash assistance offered to disabled individuals into health coverage, or vice versa, in order to maximize the efficacy of federal assistance.

Fiscal neutrality. Reforms adopted by the commission should, in total, have the net effect of maintaining federal spending on the disabled at its currently projected levels.

'DUAL ELIGIBLES' CONSOLIDATED ONTO THE REFORMED INDIVIDUAL MARKET

Approximately 10 million U.S. residents, primarily low-income retirees, are eligible for both Medicare and Medicaid. Because these individuals today gain health coverage from two very different government programs, with overlapping benefits and differing physician networks, care for these vulnerable individuals is often of poor quality and excessive cost.

Under the Universal Tax Credit Plan, all of these "dual eligible" individuals would be migrated onto the reformed individual market, where they would receive an tax credit-based insurance benefit of the same actuarial value as that represented by their existing Medicare and Medicaid coverage.

This would amount to a benchmark individual plan with the cost-sharing subsidies—in the form of health savings account subsidies—needed to achieve actuarial equivalence. In this way, dual-eligible individuals could gain coverage from a single health plan managed by a single insurer, with a unified network of physicians and hospitals. Over time, such an approach should lead to substantially higher-quality care, and lower costs, than the existing patchwork system.