EXECUTIVE SUMMARY

Coverage Isn't Care: An Abundance Agenda for Medicaid

by Craig Garthwaite and Timothy Layton

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Introduction

Medicaid now provides health insurance to nearly one in four Americans. That is more people than are covered by the public health insurance programs of the United Kingdom, Germany, or France. Though it was initially a small, inexpensive safety-net program, Medicaid is now a major national health insurance program. In *Coverage Isn't Care: An Abundance Agenda for Medicaid*, Craig Garthwaite and Timothy Layton provide an overview of the Medicaid program; put forward a framework for thinking about the appropriate structure of the program; and propose a set of fundamental reforms aimed at improving the program's efficiency.

The authors explain that the piecemeal nature of the way Medicaid has evolved over the decades has produced a Frankenstein-like program that brings together various populations, providers, operating models, and revenue streams in less-than-ideal ways. They observe that most reform proposals do not address the program's core structural flaws but instead focus on relatively marginal changes to eligibility and financing. They argue that to meaningfully reform Medicaid to be a more effective program—while maintaining the scale and scope of today's Medicaid program—policymakers must move beyond the standard focus on subsidizing demand for healthcare services and pay attention to the supply of these services to Medicaid patients.

A history of Medicaid

Medicaid was created in 1965 as a small safety-net program providing health insurance to the aged, blind, and disabled, as well as to very-low-income families with children. It originated as a voluntary program in which states could choose to participate but were incentivized to do so through federal matching funds.

Eligibility expansions beginning in the 1990s set the stage for rapid growth. Congress first expanded eligibility to higher-income pregnant women and children (those with incomes under 133 percent of the Federal Poverty Line [FPL] for pregnant women and children under six). In 1997, the State Children's Health Insurance Program (SCHIP, later known as CHIP) was introduced. Through this program, Congress offered matching funds to states to cover children in families with incomes higher than the national Medicaid eligibility levels. Many states set eligibility for children at 200 percent of the FPL. Finally, the 2010 Affordable Care Act extended coverage to all adults with incomes below 138 percent of the federal poverty line. The federal government incentivized states to raise this income threshold by offering high matching rates, initially covering 100 percent of costs for this expansion population and then settling permanently at 90 percent.

Medicaid coverage and financing

As a result of the expansions mentioned above, Medicaid enrollment grew from 20 million people in 1990 to 78.5 million people in 2024, almost one-fourth of the US population. The largest enrollment group today is children under age 18; this group makes up nearly 40 percent of all enrollees but accounts for only 16 percent of spending. Non-elderly adults with disabilities make up 12 percent of enrollees but account for 33 percent of spending. The elderly (not in long-term-care facilities) make up 10 percent of enrollees and account for 22 percent of spending. A fourth group, individuals in long-term care facilities, comprise only 5 percent of the Medicaid caseload but account for nearly 30 percent of Medicaid spending.

Medicaid is jointly funded by the states and the federal government. The federal government matches state spending through the Federal Medical Assistance Percentage (FMAP) formula. The FMAP for each state is a function of the state's per-capita income relative to the national per-capita income, with a lower bound of a 1:1 federal-to-state match (50 percent FMAP) and an upper bound of an almost 5:1 federal-to-state match.

As Medicaid was expanded to cover additional populations, Congress included more generous matching rates to incentivize states to undertake these expansions. The CHIP program included an "enhanced" FMAP for children in higher-income families with a minimum match of 65 percent instead of the standard 50 percent. The FMAP was further expanded for the population covered under the ACA Medicaid expansion, which is almost entirely paid for with federal dollars (90 percent FMAP).

States have also been able to boost federal matching funds via other methods. For instance, states tax hospitals and other providers and then replace that lost revenue via lump sum transfers to hospitals or higher hospital payment rates, which trigger federal matching payments and allow states to effectively extract federal dollars without paying anything out of their own budgets.

Because federal rules require states to cover most medical services, and because many eligibility rules are now determined at the federal level (although states can still set income eligibility levels and decide whether to cover additional services such as vision or dental), states generally control Medicaid spending by paying low rates to providers. Low rates keep spending down both in that providers are paid less for the same services and in that few providers are willing to accept Medicaid enrollees. Today, Medicaid patients have a much harder time finding a doctor than other patients do.

Commonly discussed Medicaid reform proposals

The authors discuss the impact and feasibility of three commonly proposed categories of Medicaid reforms.

FMAP adjustments. Reducing the federal matching rate of state spending—particularly the 90 percent match for the ACA expanded population—or restricting the ability of states to "game" the matching system could generate substantial federal savings. However, such changes would almost certainly do so through reduced enrollment, as states reverse prior expansions that were funded with the higher match rate. Indeed, many states that expanded Medicaid after the ACA was passed included automatic exit clauses that are triggered if the FMAP for the expansion population is lowered below the 90 percent level.

Administrative burdens and work requirements. Work requirements and administrative burdens, such as subjecting enrollees to more frequent eligibility redeterminations, would achieve cost savings almost entirely by reducing the number of people covered. Evidence suggests that work requirements have little impact on labor supply but do significantly reduce enrollment. In this way, these are policies of rationing, not structural improvement.

Block grants and per-capita caps. Another reform idea frequently discussed is shifting Medicaid from a federal match scheme to a block grant model under which states would receive a fixed amount of funding each year from the federal government and would then be responsible for any excess spending. The authors suggest that this type of reform might lead states to maintain enrollment levels but make Medicaid a less generous program per person, in contrast to reforms that would limit federal spending through reduced enrollment. States might do this through prescription drug caps, lower provider-payment rates, and elimination of optional benefits like dental coverage.

A road map for structural reforms

Garthwaite and Layton observe that Medicaid's significant growth has happened within a structure that relies on low provider payments, which has resulted in a safety-net program that falsely promises access to mainstream medical systems while only providing funds that can support a two-tiered one. They argue that instead of taking this system as given and trying to reform it with tweaks to the generosity of benefits or the level of enrollment, broader reforms are needed to establish the supply of a dedicated tier of lower-cost providers who offer Medicaid patients cost-efficient access to basic healthcare.

To facilitate this separate tier of healthcare coverage, the authors propose a series of supply-side reforms designed to relax the reliance on expensive clinical labor in care delivered to Medicaid patients:

Relax restrictions on foreign-trained doctors. Current licensing rules severely limit the ability of international medical school graduates (IMGs) to practice in the United States. Loosening these restrictions in areas with a large share of Medicaid patients could quickly expand the pool of providers.

Expand the scope of practice for mid-level providers. State laws often prevent nurse practitioners and physician assistants from practicing independently. Easing these restrictions to specifically allow such providers to treat Medicaid patients would lower labor costs and increase the supply of basic care, particularly primary and preventive services.

Augment the expanded workforce with AI. Loosening regulations to allow for AI-augmented care for Medicaid patients is key to creating an abundant supply of basic care. IMGs and mid-level providers augmented with AI tools trained on the actions of elite physicians would allow the expertise of top specialists to be scaled efficiently across the entire system.

In addition, Garthwaite and Layton propose state and federal investments to cover high fixed costs for providers to enter the Medicaid tier. Such investments include subsidies for the construction of new safety-net healthcare facilities. In line with the regulatory changes proposed above, these facilities could operate under more flexible staffing and scope-of-practice rules and could adopt AI tools to enhance the quality of the coverage they provide. The authors note that these changes could be made within the existing Medicaid budget by repurposing funds from existing inefficient programs, including the Disproportionate Share Hospital program that is the subject of many "fiscal shenanigans" today.

ABOUT THE AUTHORS

Craig Garthwaite

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Craig Garthwaite is the Herman R. Smith Research Professor in Hospital and Health Services, a Professor of Strategy, and the Director of the Program on Healthcare at Kellogg (HCAK). He is an applied economist whose research examines the business of healthcare with a focus on the interaction between private firms and public policies. His recent work in the payer and provider sectors has focused on the private sector effects of the Affordable Care Act, the impact and operation of Medicaid Managed Care plans, the responses of non-profit hospitals to financial shocks, and the economic effects of expanded social insurance programs such as Medicaid and Medicare for All. Professor Garthwaite also studies questions of pricing and innovation in the biopharmaceutical sector. In this area he has examined the effect of changes in market size of investments in new product development, the evolving world of precision medicine, expanded patent protection on pricing in the Indian pharmaceutical market, the innovation response of United States pharmaceutical firms to increases in demand, and the relationship between health insurance expansions and high drug prices. His research has appeared in journals such as the Quarterly Journal of Economics, the American Economic Review, the Annals of Internal Medicine, and the New England Journal of Medicine. Garthwaite received a B.A. and a Masters in Public Policy from the University of Michigan and his PhD in Economics from the University of Maryland. Prior to receiving his PhD, he served in a variety of public policy positions including the Director of Research for the Employment Policies Institute. He has testified before the United States Senate, United States House of Representatives and state legislatures on matters related to the healthcare markets, prescription drugs, the minimum wage, and health care reforms.

Timothy Layton

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Timothy Layton is an associate professor of public policy and economics, specializing in health economics, at the Frank Batten School of Leadership and Public Policy at the University of Virginia. Layton's research focuses on the economics of health insurance markets, with a particular focus on markets and social health insurance programs for low-income households. His research involves a mix of empirical and conceptual work studying how and why health insurance markets often struggle to provide the contracts consumers want at prices they can afford. He is an international expert in adverse selection in health insurance markets and policy tools to correct selection-induced market distortions. He also studies the design of social insurance programs, especially Medicaid and Medicare, with particular focus on private provision of public social insurance benefits and how to design programs that are optimized for the poorest and most vulnerable Americans.

Layton is a Research Associate at the National Bureau of Economic Research and an affiliated researcher at J-PAL at MIT. He sits on the editorial board of the American Journal of Health Economics and will start a term as an editor at the Journal of Health Economics in January 2025. Prior to coming to UVA, Layton was the 30th Anniversary Associate Professor of Health Care Policy at Harvard Medical School.

Layton's research has been published in top economics journals including the American Economic Review, American Economic Review, Insights, the Journal of Political Economy, the Review of Economics and Statistics, American Economic Journal: Applied, American Economic Journal: Economic Policy, and the Journal of Health Economics. He has also published widely in top clinical and health policy journals such as the New England Journal of Medicine and Health Affairs. He has won numerous awards for his work including the Willard Manning Memorial Award for the Best Research in Health Econometrics from the American Society of Health Economists, the Mark Satterthwaite Award for Outstanding Research in Healthcare Markets from the Kellogg School of Management, and the Outstanding Statistical Application Award from the American Statistical Association. His work is funded from a variety of sources, including grants from the National Institute on Aging, the National Institute on Minority Health and Disparities, the Agency for Healthcare Research and Quality, Arnold Ventures, and J-PAL.

Layton has taught courses on health policy and health economics and advanced econometric methods for causal inference. He has advised many students over the course of his career, many of whom have gone on to top jobs in academies, government, and industry.

He received his bachelor's degree from Brigham Young University and his Ph.D. from Boston University. He has three boys and loves mountain biking, hiking, and trail running.

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