Record enrollment in Medicaid has pushed federal spending for the program to new heights. In December 2022, Medicaid covered a record 92 million US residents, an increase of 30 million enrollees since 2010. Last fiscal year, federal outlays for Medicaid approached $600 billion, with many more billions spent by state governments. Despite this record spending, Medicaid enrollees have more difficulty scheduling health care appointments than commercially insured patients, and they experience mixed results regarding the quality of care received.1,2

Legislative changes over the last 15 years account for most of the recent increases. Nearly 1 in 6 recipients now qualify through the Affordable Care Act (ACA) Medicaid expansions, and they have experienced improved access to care, increased use of health services, and affordability of health care. That number will increase following Medicaid expansion in North Carolina, which on April 1, 2023, became the 40th state to approve this expansion. Since 2020, COVID-19 rules temporarily discouraged states from disenrolling ineligible individuals. These rules are currently being phased out, and millions of individuals who no longer meet the program's income requirements will be disenrolled.

Although the eligibility expansions offer new benefits to those who otherwise would not qualify, they do little to help existing Medicaid patients. Instead, the expansions have strained the existing system and increased wait times for some.3,4

The problem is not a lack of spending; it is how the money is being spent. But recent federal actions have focused on adding to enrollment, rather than ensuring that Medicaid works for its beneficiaries or that states have the flexibility to design health solutions that work well for their residents.

As the enrollment boom subsides after COVID-19, policy makers have an opportunity to rethink how Medicaid works for remaining recipients.

The ACA’s Section 1332 State Innovation Waivers and Medicaid’s Section 1115 waivers provide states with vehicles to experiment with new models of care for Medicaid recipients. Section 1115 waivers have been around for decades, but section 1332 of the ACA includes potentially expansive waiver authority that holds tremendous promise for new and innovative state-based systems of coverage and care delivery. With these waivers, states can use federal dollars (from Medicaid and beyond) to provide coverage to their residents that is at least as affordable, widespread, and comprehensive as that in the ACA. Although a few states have discussed the use of section 1332 waivers for more dramatic reforms that would affect participants in the individual and small group markets, their use has remained relatively limited because of the measure of control that presidential administrations have to approve applications. Congress should consider legislation that would simplify the waiver application process, clarify and streamline the standards that states must meet to receive a waiver, and create a fast-track process for states that have already received a waiver and want to renew or modify it.

State lawmakers do not have to look far for good ideas to deploy through section 1332 waivers. Over the last 2 decades, demand-side health care reforms have given consumers more control over their health care future. Health savings accounts (HSAs) embody this idea. Although they are not for everyone and are still saddled with restrictions that prevent broader adoption, HSAs are popular with
users who willingly forego high-premium plans for an opportunity to save dollars tax-free. The result is a better incentive structure; studies show HSAs have reduced health care use among participants.5

States could use section 1332 waiver authority to adopt similar saving vehicles for Medicaid recipients. This would help not only to promote saving and ownership among beneficiaries, but also encourage smarter consumption of health benefits. States could give Medicaid participants HSA access in conjunction with their coverage and fund those accounts to help offset costs, including co-pays at the point of service. Depending on state budget constraints, these cost-sharing requirements could feature annual out-of-pocket maximums that match the annual contribution to the recipient’s savings vehicle. This would ensure recipients would not be made worse off.

Rules would be needed to prevent withdrawals for nonqualified spending for a certain amount of time. Importantly, like traditional HSAs, participants could spend their accounts on any qualified medical spending, regardless of whether a service is currently covered by Medicaid. For example, Medicaid recipients could use a portion of their contributions to pay for nontraditional coverage options or services that may not be covered, such as dental benefits. In addition, when they leave Medicaid, recipients should be able to retain their HSA balances and use them in conjunction with employer-sponsored or other private plans (subject to existing federal rules governing HSAs).

Seemingly similar reforms have been proposed before, but they suffer from several shortcomings. The Healthy Indiana Plan offers Medicaid recipients an alternative that includes contributions to a HSA. Participating individuals are required to make contributions to the plan—anywhere from $1 to $20 per month. State and personal contributions to the accounts total $2500 per year. In exchange, participants have an annual deductible of $2500. Any spending above that amount is covered directly by the state’s Medicaid program.

The aim of the Healthy Indiana Plan was to create incentives for participants to think about their own health care consumption, as well as to promote saving and personal ownership of the accounts. Nevertheless, the Healthy Indiana Plan includes many complex rules that restrict the use of the savings accounts. Participants never fully own their account balance. And only their contributions (and not money from the state) can be returned to them if they leave the program in good standing. These policies reduce incentives to be price conscious and fail to give recipients more control over their health care.

Pairing HSAs with Medicaid would maintain health coverage, but unlike standard Medicaid, would give beneficiaries an asset that offers value beyond traditional Medicaid coverage. The accounts would offer them more choice in the health care they consume and the potential for greater financial security in the long run.

Currently, federal rules force most Medicaid recipients into coverage without major options. This contrasts with the expansion of private coverage options, particularly after the pandemic. Recent expansions in Direct Primary Care and consumer-directed health arrangements, for example, have given those with job-based coverage more choices. Changes to existing waiver rules would allow innovations from private coverage to potentially extend to Medicaid beneficiaries as well.

Medicaid recipients should have more of the same choices that individuals in private coverage have, and states are well positioned to offer it.

ARTICLE INFORMATION
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Conflict of Interest Disclosures: None reported.
Additional Contributions: I gratefully acknowledge Daniel L. Heil and Tom Church (Hoover Institution at Stanford University) who contributed to the policy insights presented in this article and received no compensation for their contributions.

REFERENCES


