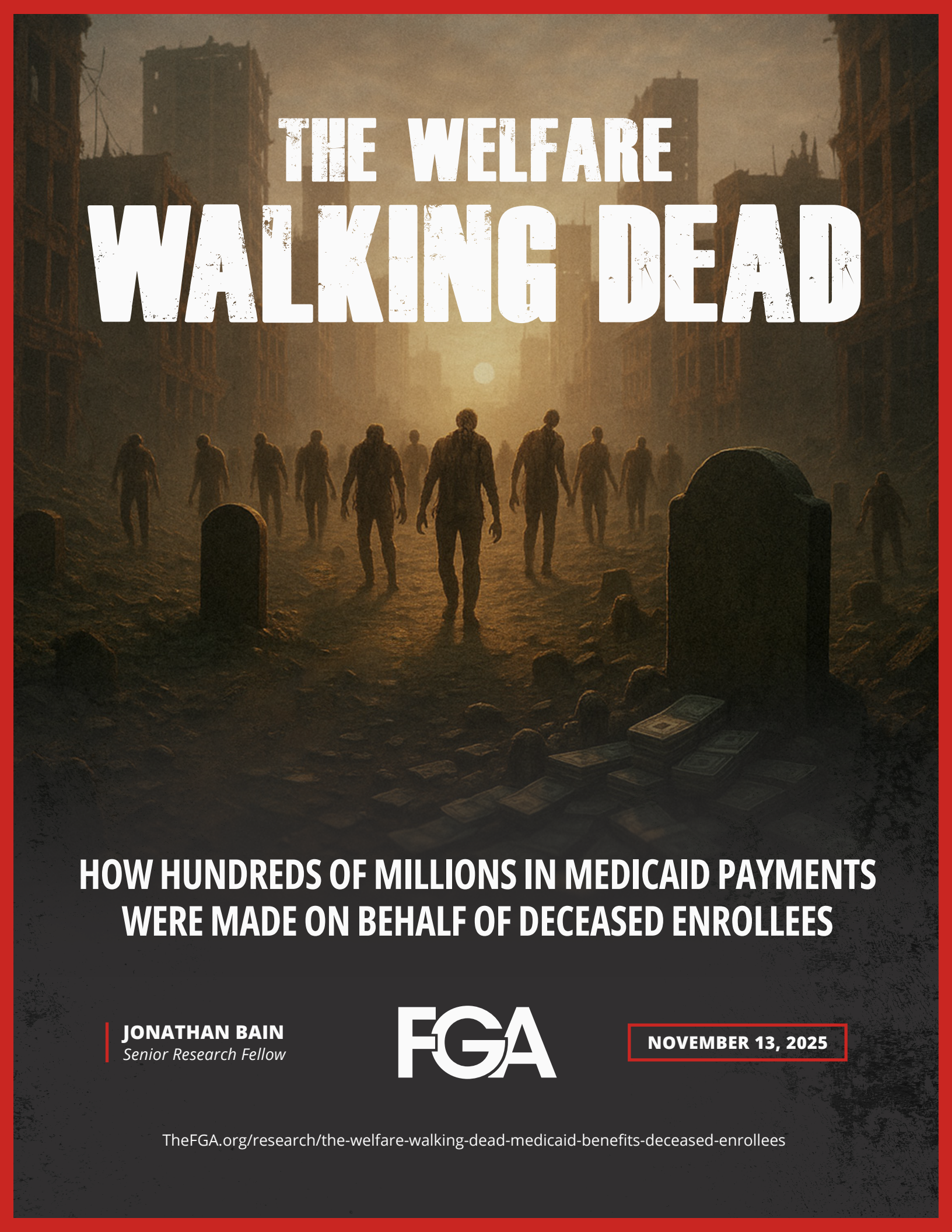




THE WELFARE WALKING DEAD

**HOW HUNDREDS OF MILLIONS IN MEDICAID PAYMENTS
WERE MADE ON BEHALF OF DECEASED ENROLLEES**

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KEY FINDINGS



1 BLOATED MEDICAID ROLLS HAVE **FUELED MASSIVE COST OVERRUNS.**

2 AS THE MEDICAID PROGRAM HAS BALLOONED IN SIZE, SO HAVE THE **LONGSTANDING PROBLEMS OF WASTE, FRAUD, AND ABUSE.**

3 **TAXPAYERS ARE FOOTING THE BILL FOR TENS OF BILLIONS OF DOLLARS ANNUALLY** IN MEDICAID IMPROPER PAYMENTS, THE VAST MAJORITY OF WHICH ARE DUE TO ELIGIBILITY ERRORS.

4 FEDERAL AUDITORS DETERMINED THAT MORE THAN **450,000 MEDICAID PAYMENTS—TOTALING \$249 MILLION—WERE MADE ON BEHALF OF DECEASED ENROLLEES.**

5 STATES SHOULD **REQUIRE AGENCIES TO REGULARLY CROSS-CHECK THE SOCIAL SECURITY ADMINISTRATION'S DEATH MASTER FILE** AND STATE VITAL STATISTICS DATA TO IDENTIFY DECEASED ENROLLEES.

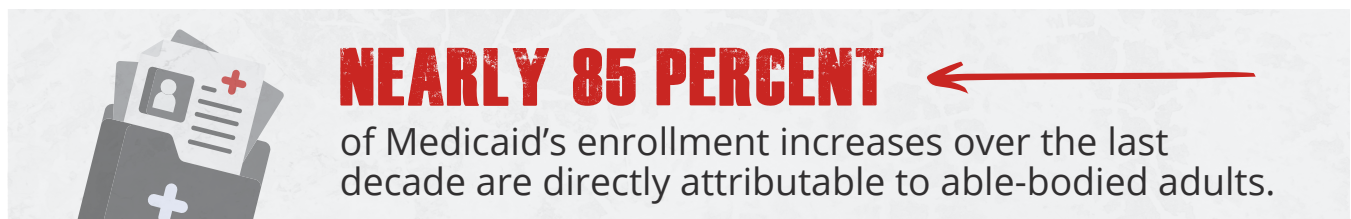
THE BOTTOM LINE:

States should remove deceased enrollees from their Medicaid programs to restore program integrity.

Overview

The Medicaid program was designed as a safety net for the truly needy—such as low-income children, the elderly, and individuals with disabilities.¹ However, the program has strayed from its original vision over the last decade, as intentional policy decisions have prioritized able-bodied adults over those the program was designed to serve.²

When the Affordable Care Act—more commonly known as ObamaCare—became the law of the land, states were given the option to expand Medicaid to an entirely new class of able-bodied adults.³ Many states took the bait, resulting in skyrocketing enrollment and surging costs.⁴ Unsurprisingly, nearly 85 percent of Medicaid's enrollment increases over the last decade are directly attributable to able-bodied adults.⁵ As enrollment has grown, so has waste, fraud, and abuse.⁶



Medicaid has been susceptible to waste, fraud, and abuse for decades, but as the program has become the largest line item in most state budgets, the problems have only gotten worse.⁷ More than one out of every five dollars that flows through Medicaid is improper, resulting in tens of billions of taxpayer dollars annually in improper payments.⁸ The vast majority of these improper payments are due to eligibility errors.⁹

Without a change, the Medicaid program was on track to surpass \$2 trillion in improper payments over the next decade.¹⁰ Thankfully, Congress passed, and President Trump signed, the One, Big, Beautiful Bill, which reprioritizes program integrity in Medicaid.¹¹

Bloated Medicaid rolls have fueled massive cost overruns

In 2000, total Medicaid enrollment was only 35 million people.¹² But by 2023, enrollment had skyrocketed to 100 million, and nearly one-third of the country was on Medicaid.¹³ This enrollment surge was primarily fueled by able-bodied adults made eligible through ObamaCare expansion.¹⁴ **Up from just seven million in 2000, a whopping 34 million able-bodied adults are now enrolled in the program—an increase of 393 percent, more than quadrupling.**¹⁵

Unfortunately for taxpayers, this enrollment surge was accompanied by soaring costs. Since 2000, total Medicaid spending has more than tripled, with costs tallying in at \$919 billion in 2023 alone.¹⁶ Federal taxpayers have borne the brunt of this spending surge, with federal dollars covering 80 percent of costs over the previous decade.¹⁷ Even worse, federal taxpayers now spend more on Medicaid for able-bodied adults than they do for individuals with disabilities, the elderly, or low-income children.¹⁸

Medicaid is consuming state budgets at a rate never seen before, quickly becoming the largest line item in most state budgets.¹⁹ In 2000, Medicaid accounted for roughly 20 percent of state budgets.²⁰ However, Medicaid now consumes 30 percent of state budgets nationwide—a 53 percent increase.²¹ This increase in Medicaid spending has not occurred in a vacuum. Other priorities—such as K-12 education, public safety, and transportation—have seen their share of the budget decrease to accommodate the surge in Medicaid spending.²²

It is no coincidence that non-expansion states have weathered the storm better than their expansion counterparts. In 2023, expansion costs catapulted to \$139 billion, roughly three times more than the so-called experts projected.²³ Making the situation more dire, **total ObamaCare expansion spending has surpassed more than \$1 trillion in less than a decade's time—shattering projections by more than double.**²⁴

As Medicaid has experienced seismic growth, so too have the program integrity issues that have long plagued it. As a result, taxpayers have been left holding the bag for tens of billions in waste, fraud, and abuse.

The Medicaid program has been plagued with waste, fraud, and abuse

As the Medicaid program has expanded in size, the longstanding program integrity challenges have become increasingly difficult to overlook. Unfortunately, the growth in the Medicaid program has been accompanied by a troubling rise in waste, fraud, and abuse.

Currently, more than one out of every five dollars that flows through Medicaid is improper, resulting in tens of billions of taxpayer dollars annually in improper payments.²⁵ Even more concerning is that more than 80 percent of these improper payments are attributable to eligibility errors.²⁶ In many instances, individuals are enrolled despite not meeting eligibility requirements or remain on the program long after they are no longer eligible.²⁷ This is not a minor system flaw, but rather a structural problem that undermines the integrity of the program as a whole.

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For decades, states were required to check Medicaid enrollees' eligibility at least once every 12 months.²⁸ States had the option to review eligibility more frequently if they chose to do so. However, in 2012, the Obama administration finalized a rule prohibiting states from conducting redeterminations more than once per year for non-disabled and non-elderly Medicaid populations, transforming the former minimum into the new maximum.²⁹ This was reinforced in 2024 when the Biden administration finalized a rule that not only prohibited states from conducting redeterminations for all eligibility groups more than once per year, but also required lengthy "reconsideration" periods that allowed ineligible enrollees to remain on the rolls for extended periods.³⁰

Eligibility errors have historically accounted for most improper Medicaid payments. In 2014, the Obama administration suspended reviews of eligibility errors, a decision that coincided with the enrollment of millions of able-bodied adults through ObamaCare expansion.³¹ Although the first Trump administration later reinstated eligibility reviews, they were once again suspended under the Biden administration.³² As a result, there was an estimated \$1.1 trillion in improper payments over the past decade.³³

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over the past decade

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In 2024, the Biden administration claimed that it had improved the integrity of federal programs by reducing Medicaid’s improper payment rate by more than 75 percent since 2021.³⁴ However, this decline did not reflect actual improvements. According to the Government Accountability Office (GAO), the reduction was due to “flexibilities granted to states during the COVID-19 public health emergency.”³⁵ In other words, because states were barred from removing ineligible enrollees during the public health emergency, “payments that would have previously been determined to be improper would not be improper under the relaxed requirements.”³⁶

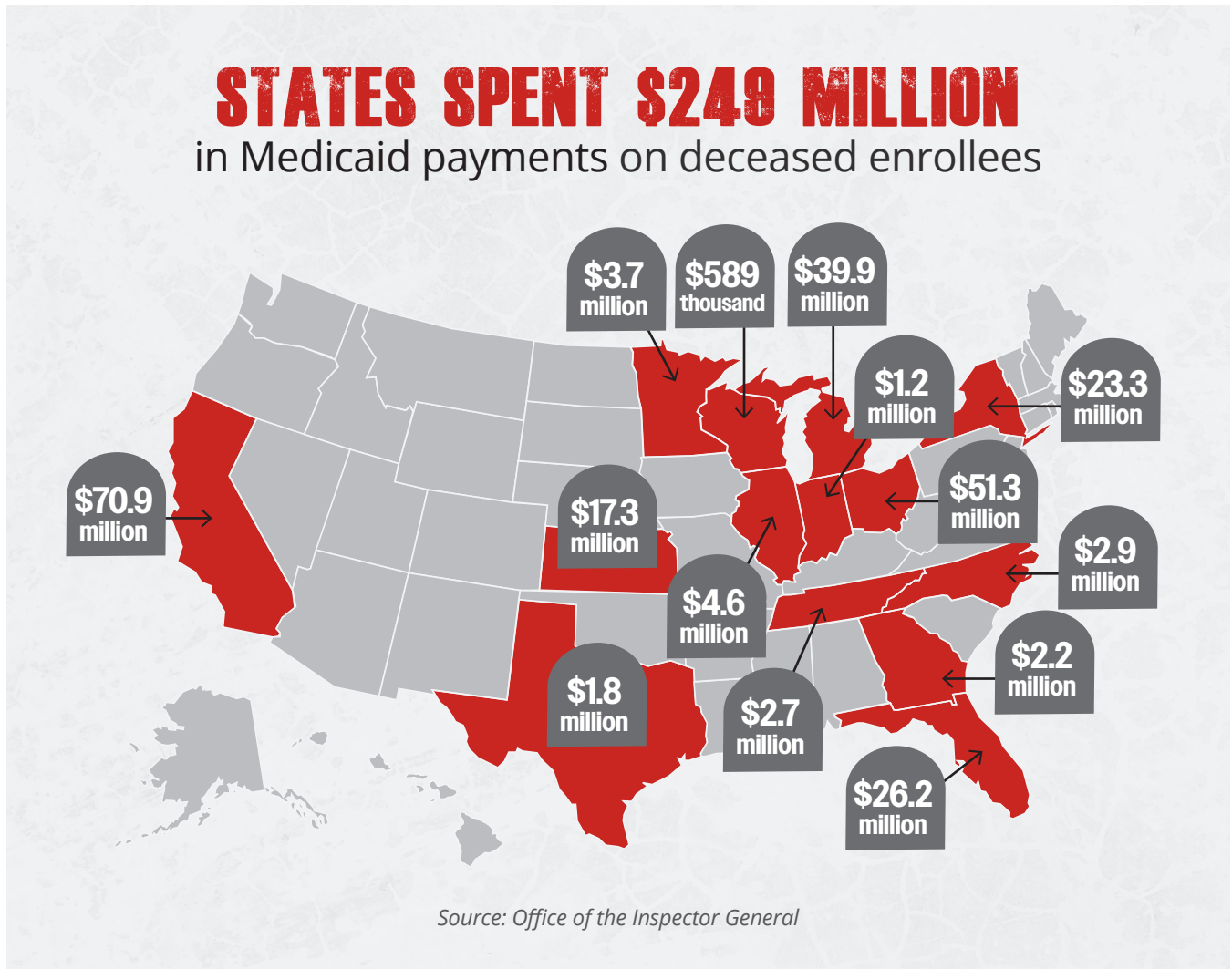
Waste, fraud, and abuse have persisted in the Medicaid program for years. One of the most troubling drivers of improper payments has been the failure to promptly remove deceased individuals from the Medicaid rolls, allowing millions to be paid out on behalf of deceased enrollees.

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Millions of Medicaid dollars are being paid on behalf of deceased enrollees

Auditors have concluded that massive amounts of waste, fraud, and abuse occur within the Medicaid program in a variety of ways.³⁷ Examples include concurrent enrollment (beneficiaries enrolled in multiple states simultaneously), stolen identities, individuals who fail to meet eligibility requirements, and even payments made on behalf of deceased individuals.³⁸

Auditors have determined that hundreds of millions of dollars in Medicaid payments have been spent on deceased enrollees, including individuals who died as early as 1981.³⁹ The Office of the Inspector General (OIG) audited 14 states and found that more than 450,000 Medicaid capitation payments were made on behalf of deceased individuals from 2009 to 2019.⁴⁰ In total, states doled out \$249 million in Medicaid payments on behalf of deceased enrollees.⁴¹



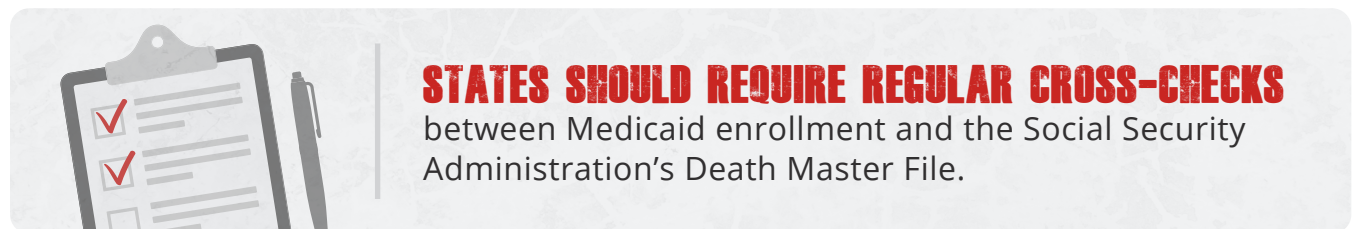
According to the OIG report, most states did not routinely identify and process enrollees' death information or enter enrollees' death information into their Medicaid Management Information System, despite the information being readily available.⁴² Some states in the audit had inadequate policies and procedures and did not identify deceased enrollees through their monthly review process.⁴³ Even worse, some of the audited states did not collaborate with entities that provide death information at all.⁴⁴

Fortunately, states can take simple program integrity measures to prevent further waste, fraud, and abuse and ensure that resources are preserved for the truly needy.

Stopping ghost payments at the state level

States should take steps to immediately begin removing deceased individuals from their Medicaid programs. Officials often have access to information like death records, tax filings, incarceration records, and more, that they do not cross-check against Medicaid enrollment.⁴⁵ This results in deceased individuals staying on the Medicaid rolls and managed care organizations continuing to collect taxpayer dollars that they are not entitled to.

To curb this problem, states should require regular cross-checks between Medicaid enrollment and the Social Security Administration's Death Master File. This can help ensure that deceased individuals are quickly removed from the Medicaid rolls and that limited taxpayer resources are directed to the truly needy. States should also require agencies to regularly cross-check state vital statistics data to identify deceased enrollees.



States can also promote program integrity by eliminating automatic renewals, prohibiting the use of pre-populated enrollment forms, and requiring beneficiaries to report significant life changes that could impact eligibility.

These are commonsense steps that states can take to reduce the waste, fraud, and abuse permeating throughout their Medicaid programs. The information already exists; states just need to utilize it.

THE BOTTOM LINE: States should remove deceased enrollees from their Medicaid programs to restore program integrity.

The original goal of the Medicaid program was to provide a safety net for the truly needy. Unfortunately, years of unrestrained growth, soaring costs, and rampant waste, fraud, and abuse have undermined the program and left the truly needy at the back of the line.

Fortunately, President Trump and Congress addressed these longstanding issues through the One, Big, Beautiful Bill, bringing much-needed reform to the Medicaid program. To reprioritize program integrity, state lawmakers should require agencies to regularly cross-check the Social Security Administration's Death Master File and state vital statistics data to identify deceased enrollees.

Implementing these program integrity measures would prevent further waste, fraud, and abuse and ensure that resources are preserved for those the Medicaid program was designed for—the truly needy.

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