EPI Issue Brief

Issue Brief #109 Economic Policy Institute November 8, 1995

The Republican Proposal to Fix Medicaid: Bad Medicine

by Edith Rasell

The Republicans in Congress are proposing seismic changes in Medicaid, which provides health care to low-income families and the blind, disabled, and elderly poor. The Republican House-Senate budget compromise would cut $182 billion from the program over seven years, which means that by 2002 federal Medicaid expenditures would be 30% below the level currently projected. The Administration's counterproposal would cut $54 billion over seven years. There are only a few ways that federal expenditures for Medicaid can be reduced, namely: deliver care more efficiently, reduce either the number of beneficiaries or payments per beneficiary, or require the states to increase their contributions. Unfortunately, these measures will not produce the desired savings, and will instead seriously cripple an already weakened program.

Savings Through Greater Efficiency

Policy makers at both the state and federal levels often argue that enrolling Medicaid beneficiaries in managed care plans such as health maintenance organizations (HMOs) will contain or even reduce expenditures while preserving existing levels of benefits. However, an examination of the evidence presents a less optimistic view. Evaluations of Medicaid managed care plans in 12 states found that in seven states costs were reduced (from 5% to 15%) and in two states they rose; in the remaining three states the results were mixed, unchanged, or unknown (Hurley, Freund, and Paul 1993).

These results probably overstate the effects of HMOs on total Medicaid expenditures. In most states, the only Medicaid beneficiaries being enrolled in HMOs are families, and in 1993 they were responsible for just 33% of expenditures even though they accounted for 73% of enrollees. It is unlikely that HMOs would have much effect on the 67% of Medicaid dollars spent on care for the low-income blind, disabled, or elderly, many of whom are in nursing homes. Therefore, even if all HMOs were as

effective at cutting Medicaid costs as the best cases cited in the literature-that is, they reduced costs by 15%—total Medicaid expenditures would fall by just 5%, since only one-third of Medicaid expenditures are affected. Moreover, this scenario ignores the problems with access and quality that have arisen in many places where Medicaid HMOs have been established. The use of vouchers to purchase care from an HMO, one proposed option, will not boost these savings.

Savings Through Reducing the Number of Beneficiaries

Currently, Medicaid is an entitlement, which means that anyone who meets the eligibility criteria automatically receives coverage. Low income alone does not ensure coverage; eligible individuals also must be either pregnant, members of families with children, aged, blind, or disabled. Between 1989 and 1993, the number of Medicaid beneficiaries rose from 22.7 million to 32.1 million. Despite this record increase, 41 million people remained uninsured in 1993, including 33% of people under age 65 with below-poverty-level incomes.

As the population grows, as incomes continue to decline, and as the population ages, the number of people eligible for Medicaid will increase. Over the next five years, Medicaid enrollment is projected to rise by 21%. If eligibility for the program is restricted, or if the Medicaid entitlement is eliminated, as Republicans are suggesting, it is likely that most of the people denied coverage will become uninsured. Given demographic and economic trends and the rising numbers of uninsured, enrollment should be expanded, not restricted.

Savings Through Reducing Costs per Beneficiary

Other options for achieving savings include limiting the services covered; requiring cost sharing in the form of deductibles, copayments, or coinsurance; or cutting fees paid to providers. Currently, Medicaid covers most necessary medical services, although dental care, hearing aids, and other items are not covered in some states. Among Medicaid beneficiaries, services are often inaccessible if they are not covered. Therefore, all needed health care services should continue to be included in the benefit package.

Cost sharing has been shown to result in adverse health outcomes for people with low incomes or in poor health (for a summary of these effects, see Rasell 1995). Given that all Medicaid beneficiaries have low incomes, and that many of the disabled, elderly, and blind are in poor health, this option should be rejected.

Further reductions in payments to providers could seriously cripple the program. In 1991, Medicaid payments to hospitals were just 82% of the cost of services delivered (ProPAC 1993). In 1993, fees paid to physicians by Medicaid were just 47% of private-sector fees (PPRC 1994). In other words, a doctor treating a patient covered by Medicaid would be paid less than half of what he or she would be paid if the same patient had private insurance. It is not surprising, then, that many doctors will not treat Medicaid beneficiaries. Any additional reduction in fees will likely result in even fewer providers willing to treat Medicaid beneficiaries and even greater barriers to care.

Savings Through Increased State Spending

The cut in federal Medicaid spending is unlikely to be offset by increased expenditures by the states. While Medicaid spending is only 6% of all federal expenditures, in state budgets it is second only to expenditures for elementary and secondary education. In 1993, Medicaid accounted for 12.8% of state spending, up from 10.5% in 1991 (Kaiser Commission on the Future of Medicaid 1995). Even under the existing federal Medicaid commitment, Medicaid will continue to absorb a growing share of state budgets. To offset the Republicans' proposed Medicaid cuts, in 2002 states would need to increase their expenditures on average by an additional two-thirds.

Conclusion

The current Medicaid program, already subjected to years of budget cutting, has no easily expendable "fluff." Moreover, switching beneficiaries to HMOs is unlikely to deliver the savings anticipated by optimistic managed care advocates, and states are unlikely to increase their Medicaid expenditures to offset federal cuts. Therefore, the proposed savings will be achieved only through cuts in needed services and reductions in the number of beneficiaries, further raising the number of uninsured.

If current Medicaid coverage is maintained, there is still an alternative to rapidly rising federal and state Medicaid expenditures: the enactment of comprehensive health care reform in both the public and private sectors with universal coverage, a single payer, capital budgets, negotiated fees, and budget caps. As has been shown by the Congressional Budget Office, such a system would dramatically slow the growth in health care expenditures, not just for governments but for the private sector as well, while preserving quality and enhancing access for all.

References

Hurley, Robert, Deborah Freund, and John Paul. 1993. ***Managed Care in Medicaid: Lessons for Policy and Program Design.*** Ann Arbor, Mich.: Health Administration Press.

Kaiser Commission on the Future of Medicaid. 1995. ***Medicaid and Federal, State, and Local Budgets.*** Washington, D.C.: Kaiser Commission.

Physician Payment Review Commission (PPRC). 1994. ***Annual Report to Congress.*** Washington, D.C.: PPRC.

Prospective Payment Assessment Commission (ProPAC). 1993. ***Report and Recommendations to the Congress.*** Washington, D.C.: ProPAC.

Rasell, M. Edith. 1995. Cost Sharing in Health Insurance-A Reexamination. New ***England Journal of Medicine,*** Vol. 332, No. 17, pp. 1164-8.