Medicaid cuts: a shot in the foot

25 MAY 91

ALAN SAGER and DEBORAH SOCOLAR

The state's budget and bond-rating crises have elevated pressure to cut the Medicaid program at the worst time and in the worst ways.

The House Ways and Means Committee's 1992 budget calls for a $500 million Medicaid cut. But chopping Medicaid now is bad economics, bad politics and bad medicine. To make time for careful reform, Medicaid needs financial relief in the form of targeted and sunseted emergency tax revenue.

Because the federal government pays half the cost of Medicaid, cutting this program to balance the state budget and help the economy is like throwing a cinder block at a drowning swimmer instead of a life preserver.

Consider these findings on the effects of a $500 million Medicaid cut:

1. It reduces the state deficit by only $250 million to begin with, because the federal government pays half of the program's cost. But the drop in state tax revenue caused by the loss of the federal matching payment and the increases in the cost of other state programs for people displaced by the Medicaid cuts must also be factored in. Then, the real net saving to state government drops to $136 million.

2. It leads patients to seek more free care from hospitals. Workers and employers who still have health-insurance coverage will be asked to pay that bill. We estimate that this cost shift will amount to at least $50 million. Also, local government tax revenues will fall by an estimated $18 million. Therefore, the net saving drops to only $68 million, for a pain-to-grain ratio of 7.33-to-1 ($500 million in lost services divided by $68 million in net savings).

3. It means a loss of 5,690 jobs statewide, and a reduction of $463 million in personal income (or $2.9 million for the average state representative's district and $11.6 million for the average senator's district).

A comparison: Chopping $500 million from Medicaid takes away as many jobs (and as much federal aid) from Massachusetts as are added annually by the Central Artery/harbor tunnel project.

4. It harms the elderly, the disabled, poor children, those with mental retardation and others who need Medicaid.

There is an alternative. An earmarked tax increase of $1.92 per person monthly would make unnecessary the $500 million in Medicaid cuts. If only the wealthier half of our people paid the tax, it would double to $3.84. Doesn't it make sense for those of us who still have jobs and who are getting by (more or less) to pay a little more to help people crushed by the recession?

Support for targeted, higher taxes to sustain Medicaid is clear. According to the Massachusetts Medical Society's February 1991 survey, 62 percent of respondents agreed that state government should spend more money to provide access to health care. Seventy-two percent said they would support an increase in taxes to "ensure that all poor people have access to medical care."

If government is not there when needed most, people will lose faith in it. The recession makes Medicaid and other vital state programs more necessary than ever. The Medicaid caseload averaged around 275,000 in the late 1980s. It is projected to rise to 450,000 next year. This increase is caused almost entirely by the recession.

Overall, Massachusetts health costs are rising by 10 percent this year, to $22 billion. State government has taken little effective action to contain these costs, which burden all who live, work, or do business in the state with higher health-insurance premiums that amount to taxation without representation.

Avoiding the tough job of real cost control, state government appears obsessed with shifting Medicaid costs to others, including many patients who will not get care. This is no substitute for attacking the long-standing spending and clinical patterns that make Massachusetts' health care the most expensive in the world. According to a Federal Reserve Bank of Boston report, "because Medicaid operates as part of the state's high-cost health-care system, it cannot be reformed in isolation."

Similarly, the governor's demand that state workers pay half their health-insurance premiums shifts $2,500 to $3,500 per year in costs to workers who have not received pay raises in three years, but it does nothing to slow increases in the cost of health care.

Costs have to be controlled in ways that avoid harm to those who depend on the program. Four steps to make Medicaid affordable are:

1. At long last, build workable cost controls for Massachusetts hospitals. The need to rewrite our hospital-payment law this year makes it possible to begin this job now.

2. Continue to strengthen Medicaid administration by employing managers who can reform rates and methods of paying physicians, nursing homes and drug companies.

3. Forcing disabled and AFDC Medicaid recipients into existing HMOs that are organized to care for basically healthy, middle-income working people is no panacea. But making sure that each Medicaid patient has a primary-care physician who knows him or her, and a well-organized system of care, could pay dividends in better outcomes immediately and lower costs in the long run, through timely care and reduced use of expensive hospital outpatient departments and emergency rooms.

4. Test and evaluate methods of delivering long-term care. Disability and chronic illness pose extraordinary challenges, not only to Medicaid but also to patients, families and society.

Alan Sager is an associate professor and Deborah Socolar is a researcher at the Boston University School of Public Health.