Proposed Medicaid Cuts Target the Vulnerable

BY JANE HIEBERT-WHITE

Providing coverage for the nation's uninsured population was a key concern in the healthcare reform debate of 1993-94. In the Medicare and Medicaid debates of 1995, policymakers and healthcare leaders would do well to keep this concern in mind. The number of uninsured Americans continues to grow, and major cuts in the public insurance programs could greatly reduce access to healthcare, especially since private health insurance coverage is also on the decline.

This column provides new data from a major survey on access to healthcare and from analyses of health insurance coverage. Of particular concern is the effect that drastic Medicaid cuts could have on the nation's most vulnerable citizens and on the healthcare institutions that care for them.

Ms. Hiebert-White is executive editor, Health Affairs.

Access to Care: Current Status

Over the past two decades, the Robert Wood Johnson Foundation (RWJ) has sponsored periodic national surveys of Americans' access to healthcare. Results of the most recent survey, done in 1994, are now becoming available. The survey found that 6 percent of Americans said they could not get all the medical or surgical care they needed.[1]

This first part of the survey, released in October 1995, asked Americans whether they have received all the care they needed. Other survey components will be released in spring 1996.

The finding that 6 percent of Americans perceived a problem with their access to medical and surgical care is similar to the results of previous RWJ access surveys in 1982 and 1986. In the most recent survey, however, researchers asked respondents about components of healthcare not surveyed in the earlier studies. These included prescription drugs, eyeglasses, dental care, and mental health care or counseling. Knowing that these services are less likely to be covered by private insurance, the researchers were interested in tracking them. With this broader definition of healthcare services, the researchers found that 16.1 percent of respondents (or 41 million Americans) "were unable to obtain at least one service they believed they needed."[2]

The survey found that the highest unmet need was for dental care (8.5 percent), and the lowest was for mental health care (1.4 percent). However, the researchers note that the figure for mental health services is likely to be low, since "there is empirical evidence that survey respondents are often unwilling to report stigmatizing conditions."

African Americans had the highest level of unmet need (24 percent), using the broader definition of healthcare, compared with 18 percent for Hispanics and 15 percent for whites. There appeared to be no difference between access to care for urban and rural residents; however, this question will be analyzed further in the remaining portions of the study.

Finally, the survey indicates that three important factors in determining access to healthcare are income, the presence of a usual source of care, and insurance status. The researchers report: "Health insurance continues to be the most important correlate of unmet need. Uninsured persons are approximately two and one-half times as likely as insured persons to have an unmet need."

A survey of enrollees in managed care and fee-for-service health insurance plans supports this finding. The Commonwealth Fund's 1994 Managed Care Survey found that 11 percent of managed care enrollees reported postponing care they thought they needed in the previous year, whereas 9 percent of enrollees in fee-for-service plans postponed care.[3] The researchers reported: "The principal reasons for not seeking care in both groups were cost and lack of insurance coverage for the service needed."

Trends in Insurance Coverage

Since insurance coverage is an important factor in determining access to healthcare, it is useful to

look at recent insurance trends. In 1993, 40.9 million Americans (18.1 percent of the nonelderly population) were uninsured, up from 39.8 million (17.8 percent) in 1992.[4] These numbers, reported by the Employee Benefit Research Institute (EBRI), were based on the March 1994 Current Population Survey (CPS). The results have a 0.4 percent margin of error at the 95 percent confidence level; thus the total number of uninsured in 1993 ranged from 40.1 million to 41.7 million. Analysis of the March 1995 CPS will be available in early 1996, according to an EBRI spokesperson.

The data show that Americans' source of insurance coverage is shifting. Private health insurance is declining while public insurance coverage is on the rise. For instance, the percentage of the nonelderly population with private health insurance declined from 75 in 1989 to 69.7 in 1993. And employment-based coverage fell from 62 percent in 1992 to 60.8 percent in 1993. The percentage with public insurance, on the other hand, rose from 12.2 to 16.1 in the years 1989-93. The EBRI report attributes part of this increase in public insurance to federal legislation passed in the late 1980s requiring states to cover specific groups of people under Medicaid. The causes of the decline in private insurance are, however, more difficult to pinpoint.

Of the people without health insurance in 1993, 55.5 percent were working adults, 27.2 percent were children, and 17.3 percent were nonworking adults. The 1994 CPS included for the first time a question about citizenship status. The survey found that 43 percent of nonelderly, noncitizen respondents were uninsured, compared with 16.4 percent of citizens.

Coverage of Children Falling

A finding of critical concern is that children made up the largest proportion of the increase in the uninsured population from 1992 to 1993. EBRI reported that in 1993, 11.1 million children (16 percent) were not covered by either public or private insurance, up from 10.2 million (15.1 percent) in 1992.

The number of children without health insurance had grown dramatically from 1977 to 1987, but then seemed to stabilize between 1988 and 1992. However, according to health policy professor Paul Newacheck and colleagues at the University of California, San Francisco (UCSF), "The apparent stability . . . masks substantial underlying shifts in private and public coverage."[5]

Children make up the largest proportion of the increase in the uninsured population.

The economic downturn of the early 1990s, combined with rising medical costs and a shift to more service-sector jobs with limited or no benefits, all contributed to a decline in private insurance coverage for children, the UCSF researchers suggest. "The net result of these trends was a marked reduction in the percentage of children covered by private insurance, from 73.5 percent in 1988 to 69.3 percent in 1992. The entire decline was attributable to loss of employer-based insurance," they report.

During the same years, Medicaid coverage for children grew 45 percent (while the child population grew 5 percent). UCSF researchers attribute this growth to the mandated Medicaid eligibility changes of the late 1980s and the 1990-91 recession, which increased the number of families in poverty. The number of children in poor families increased from 19.7 percent in 1988 to 22.2 percent in 1992.

CHA's Positions on Medicare and Medicaid Cuts

Proposed cuts in funding for the Medicare and Medicaid programs pose challenges for Catholic healthcare organizations. Because they serve large numbers of the poor and elderly, many Catholic providers receive 60 percent to 70 percent of their revenue from these programs. (The percentage is often even higher for Catholic nursing homes.)

The Catholic Health Association has worked to educate members of Congress about the need to reduce the deficit through moderated Medicare/Medicaid cuts and rational restructuring of programs. The association believes Medicaid block grants must:

- Preserve the current federal minimum standards for eligibility
- Include strong accountability measures for access and quality of care

CHA supports congressional Medicare proposals that provide coordinated-care options for beneficiaries, such as provider-sponsored networks and tax-exempt integrated delivery networks. These entities could contract directly with Medicare, giving Catholic healthcare organizations the opportunity to compete successfully with other insurers for care of the elderly.

Effect of Medicaid Reforms

The twin trends of declining private insurance coverage and the 1993 increase in the overall number of uninsured for both adults and children should concern those healthcare leaders and policymakers who want to improve (or at least maintain) access to healthcare. In recent years, public health insurance has served as a mitigating force in overall insurance trends. What will it mean to severely cut public health insurance spending in the face of declining private coverage? What will it mean to move Medicaid to the states, where the recently expanded eligibility levels mandated by Congress may be eroded?

The recent Senate and House Conference Committee's recommendation for Medicaid was to reduce spending by $182 billion over seven years (relative to projected program spending increases).[6] By the year 2002 Medicaid spending would be 28.9 percent, or $52.3 billion, below the baseline, according to this plan. In September John Holohan and other researchers at the Urban Institute in Washington, DC, evaluated the effect of this level of potential budget caps on Medicaid.[7] This analysis was conducted for the Kaiser Commission on the Future of Medicaid.

The researchers estimated the total potential cost savings of various program changes to Medicaid. The analysts assumed that states would have complete flexibility in meeting the budget limits. In the end, however, it was clear that states would have to "make major changes in their Medicaid programs or substantially increase the state dollars going into the program" to meet the budget goals. Many states would likely try to cut spending per person before removing eligible people from the program. However, the Urban Institute analysts conclude that "most states would have to eliminate Medicaid eligibility for many low-income women, children, elderly and disabled persons in order to attain the budget targets."

The researchers reached their conclusion based on the following savings estimates:

- **Acute care:** Proposed savings strategies are enrolling all adults and children (including pregnant women, infants, and the medically needy) in managed care; reducing provider payments for those not in managed care; reducing optional services (dental care, vision and hearing services, podiatry, hospice care); and reducing disproportionate share payments to hospitals by one-third to one-half of the federal government's share. Total savings would range from $9.6 billion to $15.5 billion, or from 7.7 percent to 12.4 percent of total Medicaid spending.
- **Long-term care:** Proposed savings strategies include reducing nursing home payment rates by 5 percent to 10 percent; reducing or freezing nursing home bed growth for two years; lowering the income and asset levels allowed spouses who remain in the community; more aggressively limiting transfer of assets or extending estate recovery; lowering home health payment rates from 10 percent to 33 percent; reducing the scope of home health services; and reducing spending on intermediate care facilities for the mentally retarded. Total savings would range from $5.6 billion to $6.1 billion, or from 4.5 percent to 4.9 percent of Medicaid spending.

Cuts of this nature would have a drastic effect, not only on vulnerable individuals, but also on the hospitals and nursing homes that serve them.

All these cost-cutting measures add up to $15.2 billion to $21.6 billion in Medicaid savings (12.2 percent to 17.3 percent of program spending). This still does not get states close to the 28.9 percent reduction target for the year 2002, however.

Urban Institute researchers then estimated the potential savings from a number of eligibility and enrollment reductions in Medicaid: (1) eliminating the qualified Medicare beneficiary program, (2) not phasing in coverage of older children as previously mandated, (3) reducing eligibility for Aid to Families with Dependent Children to levels similar to those in welfare reform proposals, (4) cutting coverage of some or all of the medically needy, (5) eliminating eligibility for noncitizen immigrants, and (6) cutting Supplemental Security Income (SSI) eligibility for alcoholics and drug addicts. Together, these eligibility cuts would yield Medicaid savings of $9.8 billion to $21.7 billion, or from 7.8 percent to 17.4 percent of program spending.

To reach the 28.9 percent spending reduction target, *all* these estimated cuts would need to be made at their highest levels, according to the researchers. While the upper range savings of 17 percent for cost containment and 17 percent for eligibility cuts would total 34 percent, "these savings are not completely additive," Holohan and

Continued on page 16

Continued from page 12

colleagues report. Nevertheless, "28 to 30 percent is a reasonable approximation," they write.

Cuts of this nature would have a drastic effect, not only on healthcare access for many vulnerable individuals but also on the financial viability of the hospitals and nursing homes that serve them. It seems unlikely that states will have the political will to make such deep cuts. On the other hand, many states do not have the financial resources to make up the differences.

If the public sector reins in its spending on health insurance programs, will the private sector then pick up the slack? Not likely, predicted Molly Joel Coye at the September meeting in Seattle of the Association of State and Territorial Health Officials. "The private system increasingly is not going to take care of the indigent," said Coye, senior vice president of Good Samaritan Health System, a four-hospital system in San Jose, CA, and a former California state health director. "This market is brutal," she said.

As both the public and private sectors move to squeeze healthcare coverage, it is all the more critical that providers concerned about access to healthcare for the nation's most vulnerable either speak up now or prepare for new levels of charity care. □

NOTES

1. Marc L. Berk, Claudia L. Schur, and Joel C. Cantor, "Ability to Obtain Health Care: Recent Estimates from the Robert Wood Johnson Foundation National Access to Care Survey," *Health Affairs*, Fall 1995, pp. 139-146.
2. Berk, Schur, and Cantor.
3. Karen Davis et al., "Choice Matters: Enrollees' Views of Their Health Plan," *Health Affairs*, Summer 1995, pp. 99-112.
4. Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," *EBRI Issue Brief*, no. 158, February 1995.
5. Paul W. Newacheck, Dana C. Hughes, and Miriam Cisternas, "Children and Health Insurance: An Overview of Recent Trends," *Health Affairs*, Spring 1995, pp. 244-254.
6. As of early October, when this was written.
7. John Holohan et al., "Cutting Medicaid Spending in Response to Budget Caps," Urban Institute, Washington, DC, September 1995.