Focus on Medicaid

Axing Entitlement Programs

by Leslie Winner

The first phase of President Reagan's new economic policies has caused significant reductions in North Carolina's Medicaid program. Given the escalating cost of health care and the additional cuts which will be implemented by the federal government in subsequent years, North Carolina legislators are faced with a problem of major dimensions. They must either find new ways of funding health care or they must bring spiraling health care costs under control. If they can do neither, a bleak alternative lies ahead: a decrease in health care services for the poor – children, elderly, and others who in fact are North Carolina's "truly needy."

Anticipating the problems ahead for Medicaid, Gov. James B. Hunt, Jr. testified on March 10, 1981, before the U.S. House of Representatives Subcommittee on Health in his capacity as chairman of the Committee on Human Resources of the National Governor's Association (NGA). He pleaded with Congress not to make absolute and insensitive cuts in the Medicaid budget but rather to make substantive reforms in the program which would save as much or more federal dollars:

> We [the NGA] sincerely believe we can offer you an interim solution to the problem of rapidly escalating Medicaid costs without sacrificing essential health care services or denying care to the elderly poor and the needy children of this nation.... The need for health care will not disappear along with the dollars to fund it. Someone will have to meet those needs, and I fear that it will fall to our community and state institutions to care for those people perhaps in a setting or at a level that is both costly and inappropriate, but the only one available to them. My concern, then, is that we reduce Medicaid program costs, but that we do so in a way that will preserve a balanced health care package for our poorest citizens at the least cost to the taxpayer.

Despite Gov. Hunt's statement, and similar pleas by others, Congress took a sizable bite out of the Medicaid program. In the Omnibus Budget Reconciliation Act of 1981, Congress reduced by three percent the portion of the states' Medicaid programs paid for by the federal government for federal fiscal year (FY) 1982, which began on October 1, 1981. This action would then cause North Carolina to lose over the nine affected months of the state FY 82 (October 1981 to June 1982, the end of the state's fiscal year) an estimated $8.7 to $24.6 million in Medicaid funds, depending on the action taken by the General Assembly. And the losses would get larger in future years as the federal percentage declined further (4 percent in federal FY 83 and 4.5 percent in FY 84).

This cut hit the state during what was already one of the worst budget crises in years. Revenue estimates were low, the highway funds and transportation budgets were in desperate straits, and there was not enough money to give teachers and other state employees a decent cost of living raise. Given the political difficulty encountered increasing the gasoline tax in the spring of 1981, no legislator wanted to raise other taxes. And because the federal budget cuts affected many programs, Medicaid was competing with other programs for additional appropriations.

Thus, President Reagan and the U.S. Congress had saddled the General Assembly with a sizable problem – one not of its own choosing or making. The N.C. legislature, in its October budget session, had to decide whether to appropriate new *state funds* of some $8.7 million and avoid any reductions in services or to reduce the program and absorb a total cut resulting from *federal actions* of $24.6 million (see box on pages 46-47 for an explanation of these figures).

The General Assembly did not respond by increasing the state's Medicaid appropriation; instead it limited services, changed reimbursement rates, and limited the number of recipients eligible to participate in the program. In the Medicaid portion of the Appropriations Act,* the legislature included seven provisions, which for the first time:

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* Chapter 1127 of the 1981 Session Laws (HB 1392), Section 22.

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1) limited the number of physician, clinic, and out-patient visits to 18 per recipient per year, with very few exceptions;

2) limited the number of mental-health clinic visits to 18 per recipient per year;

3) limited the number of drug prescriptions to four per recipient per month;

4) eliminated 19 and 20 year-old students from AFDC-related Medicaid coverage;

5) froze reimbursement rates for doctors, optometrists, clinics, and other practitioners at June 30, 1981, payment levels;

6) changed the system for setting hospital reimbursement rates from a cost basis to a flat rate, effective November 1, 1981; and

7) froze the number of authorized new nursing home beds in the state.

These new provisions will cause severe hardships on both Medicaid recipients and other North Carolinians. A person who is dependent on receiving weekly psychiatric help at a mental health clinic, for example, can now make only 18 such visits a year. And if the person denied access to a mental clinic ends up in an institution, the cost to the state will be more than the savings netted by the change in the Medicaid coverage. For another type of hardship, consider the revenues lost from decreased reimbursements for public and non-profit hospitals. These hospitals must make up the losses in Medicaid reimbursements through either increased rates charged other patients or additional appropriations from the taxpayers or charities supporting the hospital.

What made the state take these dramatic actions instead of other alternatives? Why did doctors, institutions, and recipients let these actions happen? What are the implications of future federal budget cuts and rising health care costs for North Carolina's Medicaid program?

Answering these questions requires first an understanding of the basic structure of Medicaid. A federally regulated, medical assistance program for the poor, Medicaid is paid for by federal, state, and local funds, according to a formula established by Congress. Each year, the Division of Medical Assistance in the Department of Human Resources, which administers Medicaid in North Carolina, estimates what each aspect of the program – from nursing home care to dental needs – will cost. Then, the General Assembly sets the amount for the whole program, according to the projected costs for the upcoming state fiscal year.

Federal law requires the state to provide funds for some services (such as hospital care), but the state has the power to determine the availability of other services (such as dental care). Similarly,

Photo by Paul Cooper

Rep. Billy Watkins (l) talks with Lt. Gov. Jimmy Green and Rep. George Hux (r) during October 1981 session.

some groups of persons (such as those receiving Aid to Families with Dependent Children) automatically receive all Medicaid services, but the state can choose whether to include others (such as Social Security recipients with very high medical bills). Once persons are determined to be eligible for Medicaid, they are guaranteed – i.e., entitled to receive – all the approved services, regardless of cost; that is why Medicaid is called an "entitlement" program. Since the legislature can never know to what extent Medicaid recipients will use their "entitled" benefits during a fiscal year, the General Assembly approves an appropriation which is only an estimate of what the state will spend. The federal government reimburses the state for about two-thirds of its Medicaid costs. Thus, for every dollar the state appropriates and spends of its own money, the federal government matches that with about two more dollars of federal money.

The move to cut the federal Medicaid budget resulted in part from President Reagan's general effort to balance the federal budget at the expense of social programs and in part because Medicaid is one of the fastest increasing items in both the state and federal budgets. The elderly, who are increasing in number faster than any other segment of the population, account for the largest part of the Medicaid budget. Almost one-third of the program in North Carolina pays for long-term care in nursing homes alone, and this does not include the cost of long-term care for the mentally retarded Medicaid recipients, which is also very expensive. In addition, the reimbursement rates to Medicaid providers – doctors, hospitals, dentists, nursing homes, etc. – are tied to the accelerating rates of health care costs in general.

Faced with a federally-initiated, funding-versus-services crisis, the state had several options. In June, the General Assembly had approved $580.6 million for the total Medicaid budget for state FY 82. This amount included the federal, state, and local share, and provided the basis from which

to compute the federal share of the funds. After the reduction in the federal share, signed into law in August, the General Assembly had three choices. It could:

1) appropriate an additional $8.7 million in state funds and hold the program at its current level of services;

2) vote no additional state money and reduce services by $24.6 million; or

3) vote some additional money and reduce services by an amount less than $24.6 million.

Why did the legislature decide to cut services by an estimated $27.6 million when the state could have kept the loss resulting from federal actions to only $8.7 million?*

Barbara Matula, director of the Division of Medical Assistance for the state, agreed, in an interview for this article, that the legislators had these three options. "But I was not asked as to whether the state could make up [the cuts with] appropriations or absorb the cuts," she said. "The [state] decision was made in the spring. I was asked to present all the possible options to cut costs. At no point did they say to me, 'How much money do we need to bail out the feds?'"

As early as February 1981, Deputy State Budget Officer Marvin Dorman wrote a memorandum to the Lt. Governor, Speaker of the House, and other legislative leaders informing them that Gov. Hunt's position was that "federal cuts cannot be picked up with state funds."

The Governor's position fit in well with the partisan attitude prevailing in the legislature. The legislative leadership decided that the Democrats in Raleigh would not bail out the Republicans in Washington. As many legislators said in private, "The people need to feel the effect of the Republican cut."

In addition, there was a considerable amount of confusion about exactly what the state had to do to avoid cutting back the Medicaid program. On Thursday of the week-long October session, the legislature was debating the Appropriations Act. The Joint Appropriations Committee had responded to the federal budget cut by recommending the service and reimbursement cuts listed above. For the first time the proposal was presented to the full House of Representatives. One of the recommended cuts – limiting the number of prescriptions available to four per recipient per month – upset some members, and an amendment was offered to change the limitation from four to six.

When the chairman of the House Appropriations Expansion Budget Committee, Rep. Billy Watkins (D-Granville), rose to defend the committee's action on prescription drugs, the confusion about the Medicaid budget cut was apparent, even among the most knowledgeable and powerful of the legislators. A persuasive member of the House leadership, Watkins had to respond on the spur of the moment to an amendment which involved the complex calculations of the Medicaid appropriation. Faced with this immediate and difficult task, he mistakenly said the amendment would cost the state an extra $2.3 million, an amount the legislature would have to delete from some other budget item, if the amendment passed. While the overall cost of increasing the number of prescriptions would have been about $2.3 million, in fact, the state's share would have been only about $800,000. In other words, if the General Assembly appropriated an extra $800,000, the prescription limit could have been increased. The rest would be paid by the federal government. Told that the amendment would cost $2.3 million by the influential Watkins – who even in good faith had his figures wrong – the House defeated the amendment.

Representative Watkins' error was typical of the confusion which prevailed. Part of that confusion resulted from the complexity of the Medicaid program, which few legislators other than those involved in the human resources appropriation process understand very well. For example, during a January 1981 meeting of the House Health Committee, the members were debating some amendments to the North Carolina statute affecting Medicaid. One committee member asked quietly what the difference between Medicaid and Medicare is.**

Contributing to the general lack of knowledge about the program was confusion over an early Reagan proposal for cutting the Medicaid budget. In his initial attack on Medicaid costs, Reagan proposed to limit the growth of the federal reimbursement to five percent per year, a federal "cap" for a program increasing at nearly a 20 percent annual rate. Since Medicaid is an entitlement program, total Medicaid payments cannot be limited; the covered health care treatment of all eligible people must be reimbursed. Consequently, if Reagan's proposed cap had been enacted, the state would have had to pay 100 percent of the cost increases over the federal five-percent ceiling. During the spring 1981 session of the General

* The $27.6 million reduction exceeded even the worst option of a $24.6 million cut. Legislative sources attribute this fact to the fear that the original savings estimated for each of the program reductions were too high, and thus the total cuts needed to be higher than the $24.6 million. Also, costs were increasing faster than originally projected, especially for hospitals.

** These two programs have similar origins and names, but they operate in entirely different fashions for very different groups of people. Medicare provides major health care services for people eligible for Social Security, as a private insurance plan does, under a premium/co-payment/deductible system. Medicaid functions as an entitlement program for needy people.

Assembly, legislators grappled with the question of how to deal with a federal cap if it were enacted by Congress, an action that would have resulted in a loss to North Carolina of some $39 million. Adding the state and local match to the loss would have meant reductions in services of some $58 million. The proposed cap would have absolutely limited federal reimbursement, and anything above that cap would have had to be paid totally out of state and local funds. This proposed cap proved to be politically unacceptable to hospitals, doctors, nursing home operators, and state governments, and Congress rejected it. But the memory of the proposed cap was still fresh in October and added another layer of misunderstanding to the Medicaid debate.

All these sources of confusion contributed substantially to the final Medicaid appropriation that cut services in three areas and reimbursement rates in three others, effectively reducing the program in North Carolina by $27.6 million for the state FY 82, from an estimated $580.6 million to $553.0 million. Few legislators understood that an appropriation of only $8.7 million in state funds would have avoided any cuts in services at all.

In addition to partisanship and confusion, other forces contributed to the legislature's choice of the most drastic option. Legislators saw the Medicaid cuts as a chance to start controlling reimbursements to nursing homes, doctors, and hospitals – the parts of the program that legislators fear are

How Medicaid Cuts are Calculated

To understand the way in which the figures used in this article are calculated, follow the explanation below, step by step. The figures are estimates because no one knows the exact extent to which this entitlement program will be used by eligible recipients during the year. Unlike a direct appropriation, Medicaid budgets are approximations of the cumulative reimbursements to be paid for services rendered during the upcoming year.

1. Prior to any federal cuts, and prior to the beginning of state FY 82, the state Division of Medical Assistance and the General Assembly compiled the Medicaid costs to be incurred in North Carolina during the state FY 82. The state fiscal year starts on July 1; the federal fiscal year on October 1. The federal cuts became effective on October 1, 1981, the beginning of federal FY 82. Therefore, only the last nine months – i.e., three quarters of state FY 82 (Oct.-Dec., Jan.-March, and April-June) – are affected by the federal cuts. This three-quarter period, then, becomes the basis for calculating the effective federal cut for N.C. FY 82.

Source of Medicaid Funds Prior to Federal Budget Cuts

		Full Year	Three Quarters[b]
		(in million dollars)	
Projected federal share	(66.6%)[a]	386.6	290.1
Projected non-federal (state and county) share	(33.4%)[a]	194.0	145.5
Projected total costs for the N.C. Medicaid program *before* any federal cuts	(100.0%)	580.6	435.6

2. The Omnibus Budget Reconciliation Act of 1981, signed into law by President Reagan in August 1981, reduced the federal reimbursement for federal FY 82 by three percent. This action reduced the federal reimbursement rate of Medicaid costs in North Carolina by two percent, and at

Notes:

[a]Before federal action in 1981, the federal share of the state FY 82 projected cost was 66.6 percent and the state/local share was 33.4 percent.

[b]These figures result from rounding.

getting out of control. Limiting the cost of inpatient treatment in hospitals and the number of long-term care beds available in nursing homes gave the legislature a foot in the door. Prior to October a combination of federal regulations and political pressure from the health care establishment had prevented the General Assembly from enacting significant controls on health care costs. The threat of even more drastic cuts in future years gave the state new leverage with these groups. Moreover, no significant pressure came from recipients, who are neither well organized nor politically powerful, to protest the limitations on services. Legal Services of North Carolina represented its clients in the October session but had little help from other groups. Since no powerful pro-Medicaid lobby was functioning in October, the legislative leaders were able to make the stringent cuts.

But even in cutting services worth $27.6 million, the legislature demonstrated some sensitivity. It chose to reduce services rather than to limit substantially the group of people eligible to receive Medicaid. Those persons receiving Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) must be included in the North Carolina Medicaid program. But the "medically needy" – often retired or disabled persons whose only income is Social Security and whose medical bills are very high – could have been eliminated entirely from the program by the General Assembly but were not.

the same time increased the state and local share by two percent.

Federal reimbursement rate prior to reduction	66.6%
Multiplied by percent reduction from federal action	x 3%
Equals decrease in federal reimbursement	1.99 or 2.0%

Consequently, the federal reimbursement rate declined from 66.6 percent to 64.6 percent:

Federal reimbursement rate prior to reduction	66.6%
Minus decrease in federal reimbursement rate	- 2.0%
Equals reduced federal reimbursement rate	64.6%

And, the state/local share increased from 33.4 percent to 35.4 percent:

Non-federal (state/local) rate prior to federal reduction	33.4%
Plus increased state/local share resulting from federal action	+2.0%
Equals increased state/local payment rate	35.4%

3. The federal action would cause North Carolina to lose over the three-quarter period in state FY 82 an estimated $8.7 to $24.6 million in Medicaid funds, depending on the action of the General Assembly. The calculations of these figures follow. Both calculations are for three quarters of the state fiscal year.

a. $290.1 million	federal reimbursement before federal cuts
x 3%	amount of reduction in federal reimbursement
$ 8.7 million	decrease in federal reimbursement

Thus, one option was for the legislature to appropriate an additional $8.7 million in state funds to make up for the decreased federal reimbursement.

b. The other option was not to increase the state appropriation but to limit the program to the existing state and local appropriations. To do that, the existing non-federal share had to cover 35.4 percent of the program costs instead of 33.4 percent (see step 2 above).

Existing non-federal share = $145.5 million.

Non-federal portion of costs after the cut = 35.4%.

$145.5 million = 35.4% (x)

x = $145.5 ÷ 35.4%

x = $411.0 million - size of Medicaid program after cut if no additional state appropriation is made

$435.6 million - size of Medicaid program before cut

- 411.0 million - size of Medicaid program after cut

$ 24.6 million - reduction in size of Medicaid program

Thus, this option required cutting the Medicaid program by $24.6 million.

This was the option chosen by the General Assembly in its October 1981 budget session.

Under the current federal legislation, the federal share of the formula decreases again next year, even as Medicaid costs keep increasing. In its budget session this June, just before the state's FY 83 begins on July 1, 1982, the General Assembly must again cope with the federal cuts. If the legislature chooses the same action it did last October – appropriate no additional money to cover the decreasing federal share – services must be reduced by some $48 million, almost twice as much as this year. And the federal reductions could get even worse.

The Secretary of the U.S. Department of Health and Human Services, Richard S. Schweiker, in a recent letter to David A. Stockman, director of the Office of Management and Budget, said that an interagency study group had approved a proposal to finance long-term institutional care, now paid for under Medicaid, through a block grant. If this proposal is accepted by Congress, long-term care would no longer be reimbursed by the federal government as an entitlement service. Instead of the federal government reimbursing the state a percentage of the expenditures for this service, it would appropriate a fixed sum to each state. The effect is the same as a Medicaid cap. The entire amount spent above the federal allocation must be paid for by the state. Thus, if long-term care is placed under a block grant, the state may have to cope with budget cuts for Medicaid services even larger than the currently estimated $48 million.

The state has traditionally considered four methods for cutting costs in the Medicaid program:

1) *Limit administrative costs and fraud.* Several minor changes were enacted by the legislature in July 1981, but no one has come up with any way to save substantial amounts by this method.

2) *Limit the services which are covered by Medicaid.* Although eliminating dentures and glasses from coverage probably will not kill anyone, growing old without them is humiliating and painful. Limitations in other services, such as the number of days in the hospital which are compensable, will undoubtedly deprive people of necessary health care or will simply shift the cost to local governments or other patients.

3) *Cut the reimbursement rate paid to Medicaid providers.* This will work only to a limited extent. At some point doctors and hospitals will opt not to participate in the program, risking a separate health care system for the poor. And, to the extent that treatment is provided by county hospitals, clinics, or mental health centers, the lost Medicaid reimbursement must be replaced by county funds. Finally, physicians, nursing homes, and hospitals have powerful lobbyists who will, as a matter of political reality, limit this option.

4) *Limit the group of people eligible to receive Medicaid.* The only group that can be cut is the medically needy, including those people who worked for a living but in retirement have high medical bills and little income. Depriving them of health care is a drastic measure.

Using a variety of budget mechanisms – from changing eligibility standards to reducing the federal share of a funding formula to considering putting some portions of an entitlement program into a block grant – the Reagan administration and Congress are slowly but surely whittling away those programs on which the poor depend for survival. State officials from throughout the country, even from traditionally conservative areas, have protested these federal actions. In a joint U.S. House Subcommittee field hearing held in Memphis on November 9, 1981, representatives from Mississippi, Tennessee, and Arkansas explained their dilemma as a choice between cutting welfare and Medicaid benefits for the poor or increasing state taxes. And, as the director of the Arkansas Department of Human Services put it: "There is simply no sentiment of any kind for a tax increase."*

If the federal government continues on its current path of eroding basic social programs, then the state will either have to pick up some additional part of the cost or it will have to commence serious efforts to create new cost saving options that do not fit into the traditional list of cost saving solutions.

Last October, the legislature instructed the Division of Medical Assistance to study some dramatic changes in health care delivery to the poor. These included increased home-based and community-based care, prepaid contracts for medical services, and statewide fee schedules for physicians, dentists, and others.

Alternatives such as these must be taken seriously. Others must be developed. Future cost raising factors must be identified and brought under control early. For example, what effect will the increasing prevalence of for-profit, proprietary hospitals have on Medicaid costs? Changes in health care delivery must be examined before it is too late to influence them.

Unless the state takes the advice Gov. Hunt gave to Congress and breaks out of its traditional mold, it will have only two choices: Appropriate substantially more money for Medicaid or deny necessary health care treatment to people who have no other way to get it.□

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* Joint Field Hearing of the U.S. House Ways and Means Subcommittee on Public Assistance and Unemployment Compensation, House Ways and Means Subcommittee on Oversight, and House Energy and Commerce Subcommittee on Health and the Environment. The chairman of the Public Assistance Subcommittee, Rep. Harold Ford (D-Tn), from Memphis, chaired this hearing.