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The Policy and Political Context of Defending Medicaid

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Abstract: Medicaid is often accused of devouring state budgets. In reality, it is a sharp decline in revenue that has precipatated the current state fiscal crisis, not the growth of health care spending. Nonetheless, in a climate of scarce resources, proponents of maintaining health coverage for low-income people through the Medicaid program face a complex challenge that requires them to think simultaneously about policy and building a political constituency for health care for the poor. At the same time, they must challenge the conventional wisdom that argues against raising taxes in times of economic weakness. **Key words:** *Medicaid, state budget, state fiscal crisis, state health policy*

STATE FISCAL DOWNTURNS, accompanied by retrenchment in state spending, are cyclical, but the trough of this current cycle seems particularly deep, with potentially devastating consequences, both short and long term, for the Medicaid program and the people who depend on it.

If the first step toward solving a problem is defining and understanding it, then the Medicaid problem will be a particularly difficult one, as a common definition of the problem continues to elude advocates for the program and its beneficiaries and state and federal officials. Some describe the state fiscal crisis as being caused by state overspending in general and Medicaid spending growth in particular. Furthermore, Medicaid spending growth is sometimes attributed to unwise and unsustainable program expansions.

An alternative explanation of the state fiscal crisis is that it is caused primarily by a combination of tax cuts in the 1990s (based largely on the implicit assumption that the revenues generated by the capital gains tax on the overheated stock market would continue indefinitely), a growing weakness in state tax structure, and an imbalance in the relationship between Medicare and Medicaid relationship.

The stakes in this debate are extraordinarily high. In the short term, health coverage is at risk for more than 1.7 million people, and millions more risk loss of benefits and will face higher financial barriers when seeking to access care (Nathanson & Ku, 2003). In addition, billions of dollars in reduced revenue for providers could dramatically undermine the health care delivery system, particularly those providers and classes of providers (e.g., community health centers, nursing homes, public hospitals) that are heavily dependent on Medicaid.

If anything, the long-term stakes are even higher. Structural program changes are on the table that could make it difficult if not impossible for people to regain lost ground even when the economy improves. Such changes could strip away the critical beneficiary protections that today are associated with Medicaid.

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Consumer organizations, providers, and others seeking to protect the Medicaid program face a complex, multipart challenge. They must persuade a critical mass of public policy makers of the inadvisability of cutting Medicaid as a (partial) solution to resolving state fiscal problems and instead refocus attention on the difficult task of securing new revenues from both the state tax base and the federal government; in tandem, they must make longer term changes in the delivery of services to Medicaid recipients that will save money without undermining the program and advocating for an increased federal role in meeting the health care needs of low-income Medicare beneficiaries.

To make matters even more difficult, the debate in Washington includes not only the prospect of additional support for state Medicaid programs, but also the possibility of the elimination of guaranteed federal matching payments for state expenditures and the loosening or elimination of many of the current federal program requirements. This means that advocates must work collaboratively across state lines while at the same time addressing their own state budget issues.

This article briefly reviews the causes of both the state fiscal crisis and increased Medicaid spending. It then reviews the substantive and political tasks that confront Medicaid's defenders, using the Massachusetts experience as a guide.

MEDICAID AND THE STATE FISCAL CRISIS

The policy and political context of the Medicaid reform debate cannot be understood outside of the context of the state fiscal crisis. It is this crisis, and Medicaid's perceived role in it, that is driving the debate over Medicaid at both the state and federal level.

That states are in a fiscal crisis and that Medicaid spending as a proportion of state spending is increasing are propositions with which there is little disagreement. According to the National Governors' Association and the National Association of State Budget Officers (as cited in a Center on Budget and Policy Priorities' article), states are facing the most serious fiscal situation since World War II. Many states continue to deal with significant shortfalls despite enacting substantial budget cuts and "drawing down rainy-day funds" (Johnson & Riberio, 2003). Aggregate state shortfalls are estimated to be $79 billion for state fiscal year 2004 (SFY04) ($80 billion for SFY03). While state revenue has declined, Medicaid spending has increased, rising from $180.9 billion in FY2000 to $227.8 billion in FY2002 (NASBO, 2003).

While these facts are not in dispute, their meaning is hotly contested. Excessive state spending is often cited by legislators and conservative think tanks as the cause of the state fiscal crisis, with Medicaid often cited as the leading culprit.[1]

However, according to the Center on Budget and Policy Priorities, the rate of state spending growth in the 1990s was actually modest compared to previous decades (Springer, 2003). While Medicaid spending accounts for 32% of the inflation-adjusted increase in state general fund spending between FY90 and FY01, the federal government covered nearly half of this increase through the federal match, and much of the increase was due to the fact that medical costs grew nearly twice as rapidly as general inflation rather than expansions of the Medicaid program. State revenue collections also grew rapidly during the 1990s, allowing states to build substantial rainy-day funds notwithstanding modest spending growth (LaPaille, 2003).

Looking at Massachusetts as a specific example, we see the same pattern. In Massachusetts, the state budget nearly doubled from $13.3 billion in 1991 to $22.6 billion in 2002. But this spending growth from 1991 to 2002 represents an inflation adjusted increase of just 2.3% annually. During the prior ten years, spending grew at an average annual rate of 4.7%. In fact, Massachusetts state spending has fallen from 9.4% of personal income to 9.2% of personal income since 1991 (St. George & Nolan, 2003). Therefore, increased spending does not account for the multibillion dollar shortfall. The shortfall is primarily a result of the large tax cuts that have been implemented since 1991, totaling a net cut of $3.7 billion after ...

the increased tobacco tax and 2001 tax package of $1.3 billion (St. George & Nolan, 2003).

Turning to Medicaid, what is driving spending is increased cost of caring for elderly and disabled, rather than the eligibility expansions for parents and children (Ku, 2003). While spending is up, the rate of increase is less than for private insurance (Kaiser Commission on Medicaid and the Uninsured, 2003). Finally, comparing state revenue growth to Medicaid spending over time reveals a stark picture—it is not so much spending growth in Medicaid but a real decline in state revenues that is driving the crisis (Kaiser Commission on Medicaid and the Uninsured, 2003; LaPaille, 2003).

While Medicaid may not be the bogeyman behind the state fiscal crisis that it is sometimes made out to be, there can be little doubt that the limitations of the state budgeting process—requirement that states balance their budgets each year—makes it difficult for states to support a program like Medicaid that is countercyclical in nature during lean economic times. As unemployment rises and income falls, more people qualify for Medicaid. This cushions the economic blow for families and, at the same time, pumps additional federal dollars into faltering state economies. The catch is that states struggle to maintain their share of Medicaid funding as available revenue declines. States have tried to address the difficulty of countercyclical spending by creating rainy-day funds. However, in many states, funds were inadequate to deal with the severity of the crisis. Massachusetts is a good example. In FY 2001, the Massachusetts rainy-day fund had a balance of more than $2 billion. However, by SFY03, the fund was reduced to $347 million with the state still facing an estimated deficit of $3 billion for FY04 (Zahradnik & Ribeiro, 2003).

ELEMENTS OF THE REVENUE CRISIS

If excessive spending on Medicaid and other public services does not explain fiscal crisis, what does? While a detailed exposition of the fiscal crisis in the states is beyond the scope of this article, the brief answer is that it is not the current weak state of the economy tax cuts enacted during the 1990s, and an eroding state tax base caused by the growth of a (largely tax-exempt) service economy have all contributed to the unprecedented nature of the current state fiscal crisis, even though the economy itself is not weaker than it was during the last downturn.

As a result of the increasing revenues in the 1990s, states enacted significant tax cuts that "are currently costing states more than $40 billion each year," accounting for roughly half of the current state budget gaps (McNichol, 2003). While the current sluggish performance of the economy has certainly played a role in the fiscal crisis, the other main contributor has been that the structure of the economy has changed while the tax structure of most states has not. In particular, the growth of Internet sales and the sale of services relative to goods have weakened the revenue raising power of state sales taxes (McNichol, 2003).

MEDICAID AND STATE ECONOMIES—PRAGMATISM VERSUS IDEOLOGY

Conventional wisdom holds that raising taxes in a time of economic weakness is harmful and will delay recovery. So powerful is this orthodoxy that the question—Harmful compared to what?—is almost never asked. State budget cuts can also harm the economy, reducing employment, undermining the supports people need to work, and reducing transfer payments and hence consumption. Nobel Prize-winning economist Joseph Stiglitz and Peter Orszag of the Brookings Institute argue that cuts may cause more damage to state economies than tax increases (Orszag & Stiglitz, 2003).

Medicaid cuts in particular have measurable short-term economic effects (as opposed to some other cuts—such as education and infrastructure—that may have serious long-term effects but are harder to measure in the short run). Part of the reason that cutting Medicaid is particularly damaging to state economies is that it involves the withdrawal from the state of federal matching funds

revenue shortfall in many states, the successful defense of Medicaid requires addressing and debunking the conventional wisdom on taxes, that the cost of not raising taxes is even higher.

It has been necessary to spend time on the fiscal crisis in order to understand properly the context and the tasks that confront Medicaid advocates. In light of the fiscal crisis, advocates must engage in three tasks simultaneously. They must build the substantive case against cuts, build the political case against cuts, and offer an alternative. Each of these tasks will be considered in turn.

Building the substantive case

Although details of cuts vary from state to state, the essential elements of the arguments against cuts are essentially similar in all cases, whether it is eligibility, benefits, or rates that are being cut. In general, the brunt of any cut will fall on Medicaid recipients. Even provider-rate cuts, while having a less direct effect than cuts in eligibility or benefits, are still likely to result in reduced quality and access to care. Most recipients are children, people with disabilities, and the elderly—groups that are generally considered "the deserving poor" for whom there is a substantial amount of sympathy and concern both among state officials and the general public. Therefore, the first task of Medicaid defenders is to make clear to the decision makers the impact that cuts will have on these populations.

A second element of the substantive case is the spill-over effect of Medicaid cuts onto the general population. Increasing numbers of uninsured and reduced provider revenue can affect the middle class as well as the poor. One of the principal effects is higher bad debt/charity care costs, which in turn translate into higher health insurance premiums, an issue of particular concern to employers faced with rapidly increasing premiums.

Another spill-over effect with broad implications is the withdrawal of federal dollars from a state economy when Medicaid is cut. Due to the "multiplier effect," the cost to a state far exceeds the federal dollars lost. Numerous studies have documented this effect.[2] Finally, Medicaid's defenders must highlight the counterproductive nature of many cuts from a state budgetary perspective. For example, reductions in prescription drug access can increase hospital costs, and reductions in mental health and substance abuse treatment can lead to increased costs for social services and criminal justice (Newhouse et al., 1978; Tamblyn et al., 2001).

Part of making the substantive case is making it to other groups—particularly providers, employers, and insurers so that they in turn will make the political case. This is particularly important because "who's delivering the message" matters as much as the message itself in the political arena. If for example, low-income advocacy groups argue that cutting Medicaid is harmful to employers, it carries less weight than if employers make the argument themselves—even if the same underlying information is used.

Building the political case: The "usual suspects" and beyond

The Medicaid population consists of seniors, people with disabilities, and low-income parents and children. Perhaps the first challenge in making an effective political argument against cuts is to unite these disparate constituencies to prevent them from being played off against each other. People who are directly affected by potential cuts have the power to influence the thinking of legislators and the general public. By telling their stories they make clear the human cost of cutting Medicaid.

However, while the voices of the Medicaid recipients must be heard in the political debate, they are not in and of themselves sufficient. Within the Medicaid population, only seniors are considered a significant voting block. The voices of beneficiaries must be augmented by others who are either directly affected or sympathetic to those who will be hurt directly. This group includes religious, labor, and civil rights organizations; voluntary health organizations (or "disease groups," as they are sometimes called), such as groups advocating for people with AIDS/HIV,

cancer, mental illness, or asthma; as well as hospitals, health centers, physicians, and even "untraditional allies," such as insurers and employers.

Together these groups need to directly petition the legislators and administrators who are making decisions about the Medicaid program and to reach them indirectly by appealing to the general public through both "earned" and paid media. Each audience requires a different message. For example, according to the Marttila Communications Group, the fiscal impact of cuts may be of most concern to some elected officials, while the impact on the health delivery system and the impact on beneficiaries may matter most to the general public (personal communication, John Marttilla, regarding polls and focus groups conducted for Health Care for All, Boston, MA, January and March 2003).

Organizations working to defend Medicaid confront a number of challenges. Effective collaboration may be hampered by differences in organizational culture. Groups may differ in their willingness to be critical of political leaders and in their style of expression. They may place differing emphasis on "inside" lobbying tactics versus "outside" community mobilization. They may also have different priorities—placing differing emphasis on preserving services, eligibility, or rates. Groups who are willing to oppose cuts may be unwilling to openly advocate for new revenue.

Finally, Medicaid advocates may have a difficult time breaking into the public consciousness. Public support for cuts is weak, and support for raising the necessary revenue may be much higher than is held by the conventional wisdom, but most members of the general public are unaware of the details of budget cuts in general and health care cuts in particular. The story is simply not told with sufficient frequency and prominence to break through. When competing against stories such as war or terrorism, the story of Medicaid cuts and their consequences may be easily overlooked.

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Offering an alternative

In the current fiscal crisis, neither the substantive nor political case against Medicaid cuts is a sufficient defense. States must balance their budgets. Those states facing large deficits will almost inevitably turn to Medicaid, since it is one of the largest spending categories in every state. To preserve vital services, advocates must present alternatives to cuts in the form of new revenue, alternative savings, or both.

In the long run, alternatives to Medicaid cuts must include both improved efficiency in the delivery of services and a rebalancing of the federal/state relationship. But there are significant obstacles to making these changes quickly. Making Medicaid more cost effective requires restructuring entrenched patterns of care delivery to better meet the needs of Medicaid beneficiaries, particularly those with chronic illnesses. It may also require an up-front investment of public funds at a time when resources are particularly scarce.

Rebalancing the federal/state Medicaid relationship would involve the federal government taking more responsibility for the "dual eligible" population of people over age 65 and people with disabilities who are eligible for both Medicare and Medicaid. As the cost of prescription drugs and long-term care (services generally covered by Medicaid but not Medicare) rises, the proportion of health care paid for by states for this population is rising. Forty-nine percent of all Medicaid spending in Ohio goes for people who also have Medicare based on data obtained from the Ohio Department of Jobs and Family Services, Office of Ohio Health Plans on January 7, 2003.

The federal government could also enhance states' ability to operate a countercyclical program such as Medicaid by providing enhanced levels of federal matching funds during economic downturns. However, the growing federal budget deficit makes it difficult

to secure new federal commitments, and increased federal spending on Medicaid must compete with other Bush administration priorities (such as reducing taxes and increasing military spending). Finally, since Medicaid is administered by the states, many federal officials may feel that the political benefits of improving the Medicaid program accrue mainly to state-level political leaders.

In sum, through a combination of delivery system changes and changes in the relative responsibility of the state and federal government, it is possible to achieve long-term savings in the Medicaid program without hurting enrollees. Unfortunately these savings are all difficult to achieve in the time frame being looked at by state budget writers (i.e., savings that can be realized within a single fiscal year).

Because the focus of state budget writers is short term, it leads to a focus on limited strategies of cutting benefits, reimbursement, or eligibility (Krause, 2003). As a result of this need for a short-term fix, Medicaid's defenders must inevitably rely on new revenue from one or more of several sources: receiving federal matching funds for current services that are being provided with state-only dollars, increasing the rate of federal match, and/or adding new taxes.

GENERALIZABLE VERSUS LOCAL POLITICAL ISSUES: THE MASSACHUSETTS EXAMPLE

While the basic dynamics described above apply to most states, local conditions will have an enormous impact on how the debate plays out. Critical variables include the depth of the budget crisis, political leadership history, and the culture of potential allies. The depth of each state's budget crisis determines how much pressure there is to cut. Political leadership is the key to both defining the problem and range of solutions considered feasible. The culture of potential allies in the health care, insurance, and wider business community varies enormously from state to state. In Massachusetts, for example, the consumer advocacy group Health Care for All (HCFA) has established working relationships with providers, insurers, and some employers. Large health care organizations, such as Partners Health Care System and Blue Cross, are also influential in the wider business community.

Massachusetts has built a substantive case against Medicaid cuts with several reports.[3] Led by the Health Care for All, Massachusetts has also engaged a wide range of actors in creating political support for Medicaid through the MassHealth Defense Group, the Civic Committee to Save MassHealth, and local community forums. The MassHealth Defense Group (MassHealth is the name of the Medicaid program in Massachusetts) brings together consumer health care, public health, senior and disability rights, and children's advocates with health care providers, insurers, labor unions, and grassroots supporters to protect and restore MassHealth. These 140 organizations work to send a unified message from the health care community. A civic committee of business and religious leaders has also formed to engage those less directly involved in health care. Statewide and local demonstrations, community meetings, and other grassroots mobilization efforts are ongoing to raise awareness about cuts in communities across the state. Media and public education campaigns (via postcards, letters to the editor, op-eds, etc.) are also ongoing.

Alternative proposals to obtain new federal matching funds, identify opportunities for savings, and provide vigorous support for new state taxes have been presented to the governor and legislators through many of the above channels. Notwithstanding, there have been cuts in eligibility and services. The exact scope is unclear as of this writing. The Senate version of the FY04 budget has many fewer cuts than the House version, but the outcome of the House/Senate conference committee remains uncertain. While Congress has recently voted to provide states with short-term fiscal relief tied to Medicaid, the House Speaker Thomas Finneran and the Senate President Robert Traviglini would like to save these funds for FY05.

Why, if advocates in Massachusetts have aggressively made the substantive and political

case for Medicaid while offering alternative savings and revenue proposals, do Medicaid beneficiaries still face the prospect of significant reductions in eligibility and benefits? The answer comes down to the factor of political leadership. Massachusetts Governor Mitt Romney promised to balance the state budget without raising taxes and without cutting core state services. While the governor's staff has worked actively to restore Medicaid eligibility to an estimated 36,000 people who have had their coverage terminated, the commitment to no new taxes overrides all other concerns. The Speaker of the Massachusetts House is more willing than the governor to entertain taxes to achieve fiscal stability but is also more committed to reducing Medicaid spending. To date, the Speaker has not engaged with the substantive arguments that cutting Medicaid is more detrimental to the people of Massachusetts than funding it. Instead, he has focused on balancing the state budget without serious regard for other considerations.

CONCLUSION

Medicaid is in crisis. Despite being as miscast as the source of states' fiscal woes, solutions that rely primarily on immediate cuts have the advantage of resonating with strongly held ideological prejudices for smaller government, privatization, and against tax increases, especially when the economy is weak. Advocates for preservation of Medicaid have a difficult, multipart job. If cuts affected Medicaid beneficiaries alone, the task would likely be hopeless. However, success is possible because cuts also hurt providers and ultimately payers and the general public.

In order to successfully defend the program, advocates must in the short-run make the case against cuts and build anti-cuts coalitions, but they also must build the case for alternatives, especially for new revenue that can come from both state taxes and the federal government. To make this case, the voices of beneficiaries must be heard, but we also must build and manage coalitions that extend beyond "the usual suspects" and tell a story that resonates with the general public—one that addresses both the values and the self-interest of average voters. Over the longer term preserving Medicaid requires making the program work better by reducing unnecessary treatment and underlying cost and by rebalancing the relationship between states and the federal government.

The Massachusetts experience illustrates both the possibilities and the challenges of defending Medicaid. In spite of a vigorous defense of the program, substantial cuts are still likely. Although a short-term reprieve is possible due to the recent passage of temporary federal relief, without success on the fronts of taxes, program restructuring, and realignment of the federal/state relationship the program will remain under siege. That this is likely to happen has less to do with the efforts of Medicaid's defenders and more to do with the absence of strong political leadership committed to preserving the program. Ultimately, the fate of the Medicaid program is not determined in isolation. The debate over Medicaid's future is part of a larger discussion about the role of taxes and publicly supported health care in creating the kind of society in which we would want to live.

NOTES

1. See, for example, Edwards, C., Moore, S., & Kerpen, P. (2003, February 12). *States face fiscal crunch after 1990s spending surge*. Briefing Paper #80, Cato Institute, Washington, DC; and Goldstein (2003, June 3). Governors finalizing plan to revamp Medicaid. *Washington Post*.
2. See, for example, *Economic Impact of Medicaid on South Carolina*, developed for the South Carolina Department of Health and Human Services by the Division of Research, Moore School of Business, University of South Carolina, January 2002; Memo from Perry Nutt, Staff Economist to Kentucky State Senator

Ernesto Scorsone, *Fiscal Effects of Medicaid Spending*, February 12, 2001; Medicaid and the Children's Health Insurance Plan: An Assessment of Their Impacts on Business Activity and the Consequences of Potential Funding Reductions, The Perryman Group, Waco, Texas, April 2003; and R. Greenbaum and A. Dasai, *County Level Effects of Medicaid Cutbacks in Ohio*, School of Public Policy and Management, Ohio State University, Columbus, Ohio, February 28, 2003.

3. See "The Facts on MassHealth, What It Is, Why It Works" and other reports available at www.hcfama.org/hcfa_contents.php3?fldID=154. See also Quigley et al. (2002).

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