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Public Sector Reports

Michigan **COMMENTARY**

Medicaid at the Crossroads

by Peter Pratt, Ph.D.

Soaring Medicaid expenditures have been a constant topic of conversation and presentation at summer gatherings of state policy makers. By my count, at least a half-dozen people claim to have been the first to call Medicaid the Pac-Man of state budgets. (In fact, Jerry Miller said it first, way back when Nintendo had not yet supplanted Pac-Man on children's video screens.)

In all truthfulness, we may need a more dramatic metaphor to illustrate Medicaid's dominance of state budgets. Nationwide, the program is projected to grow an average of 21 percent annually between 1988 and 1995, more than twice the rate of Medicare and nearly twice the rate of private health insurance. Amazing as it may seem, Medicaid could very well pass Medicare in total expenditures as early as next year. In Michigan, as in many other states, hospital voluntary contributions have significantly softened the blow to the general fund while pushing up total Medicaid expenditures enormously. This, however, will end after FY 1993. As Michigan's Medicaid director Vern Smith notes, Medicaid consumes such a large portion of the state general fund that even 5–6 percent growth, which is below the rate of increase in annual health care costs, would force the state to cut other programs.

BUDGET BUSTER OR CRUCIBLE OF REFORM?

Medicaid's reputation as a state (and now federal) budget buster coexists with another, more promising vision. In a time of political stalemate over the course of health care reform, as Vern Smith notes, Medicaid has become the vehicle for incremental reform of our health care system. This is especially true of expanding access to care for children and pregnant women. By the year 2001, every child living in poverty will be covered by the program, a fact few policy makers bemoan. While we wait patiently for "major" reform, Medicaid is quietly doing more to address the nation's uninsured population—and all the health problems that fall upon them—than most programs.

One cannot ignore that these newly eligible pregnant women and children drive up Medicaid costs. In FY 1992, they cost our state's program $100 million. Other studies show that the rising number of new recipients, more than health care price inflation, are responsible for soaring Medicaid costs.

But one also cannot ignore that caring for these people, even if more and more tax dollars are necessary, may be more efficient and humane than leaving them to their own devices. Medicaid costs per capita are lower than per capita premium costs for privately insured individuals. The federal match that states receive also limits state spending for the program. Policy makers must look closely at private sector alternatives to Medicaid before they give up on a program that, despite its rising costs, may be among the best values in health care. In fact, one could argue that its value is the primary reason that its costs have been rising so rapidly.

LESSONS FROM THE REJECTION OF THE OREGON WAIVER

Many states followed with great interest the deliberations on the waiver for Oregon's Medicaid program to ration care explicitly in order to cover all persons living in poverty. Whether one favored or opposed the Oregon proposal, the administration's decision was to be seen as a bellwether of federal willingness to allow states to experiment with major reform. Unfortunately, the administration's rejection of the waiver application comes at such a highly charged political time that its value as a precedent is not easy to discern. Only time will tell if the federal government, caught in a stalemate itself on national reform, will stifle innovation

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in the states. The best guess is that Oregon's program was too great a departure from the way we deliver care now to be acceptable to Washington. Less radical change will be necessary to satisfy the feds.

INNOVATION IN MICHIGAN

Certainly, rapidly rising Medicaid costs have emphasized the states' needs to try something, if not necessarily anything, to control expenditures. In Michigan, Medicaid moved rather painlessly to a resource-based relative value scale (RBRVS) for physician reimbursement, in no small part because physicians saw an overall 15-percent increase in reimbursement. As Vern Smith explains, the new system accomplished several policy objectives, especially offering more adequate reimbursement for primary and preventive care and office visits.

Michigan Medicaid also is continuing its push toward managed care. With all of the AFDC population in Wayne County now enrolled in some form of managed care, the program is working with physicians, public health directors, and HMOs to spread managed care to Oakland, Macomb, Genesee, and Muskegon counties. Talking to the physicians is vital, says Smith. "We are trying to maximize the number of choices for recipients. We won't go into a county until they have enough choices of doctors."

Finally, the Medicaid demonstration projects, to be funded with a $10-million chunk of the hospital voluntary contribution pool, present the state program with a unique opportunity to foster innovation. "There has never been a comparable opportunity in other states—Medicaid just doesn't award money," says Smith. Hopes are high that several of the 14 funded projects will be successful enough in improving quality and access and controlling costs to be replicated statewide.

AFTER VOLUNTARY CONTRIBUTIONS

In October, discussions will begin on how (or whether) to replace the huge voluntary contributions that Michigan hospitals made to Medicaid over FYs 1991–93. These contributions will have delivered $600 million to the state general fund in three years. Speculation has centered on a health care or hospital tax of some sort to replace Medicaid revenues that would otherwise be lost, but equally good cases can be made for a more general tax. This discussion will once again put Medicaid in the spotlight. Let's hope that policy makers look at the universe of health care costs and access, and not just the state budget, when solutions must be found. If wiser minds prevail, Medicaid can be a crucible of innovation. We have no other choice if we wish to avoid dismantling the program.