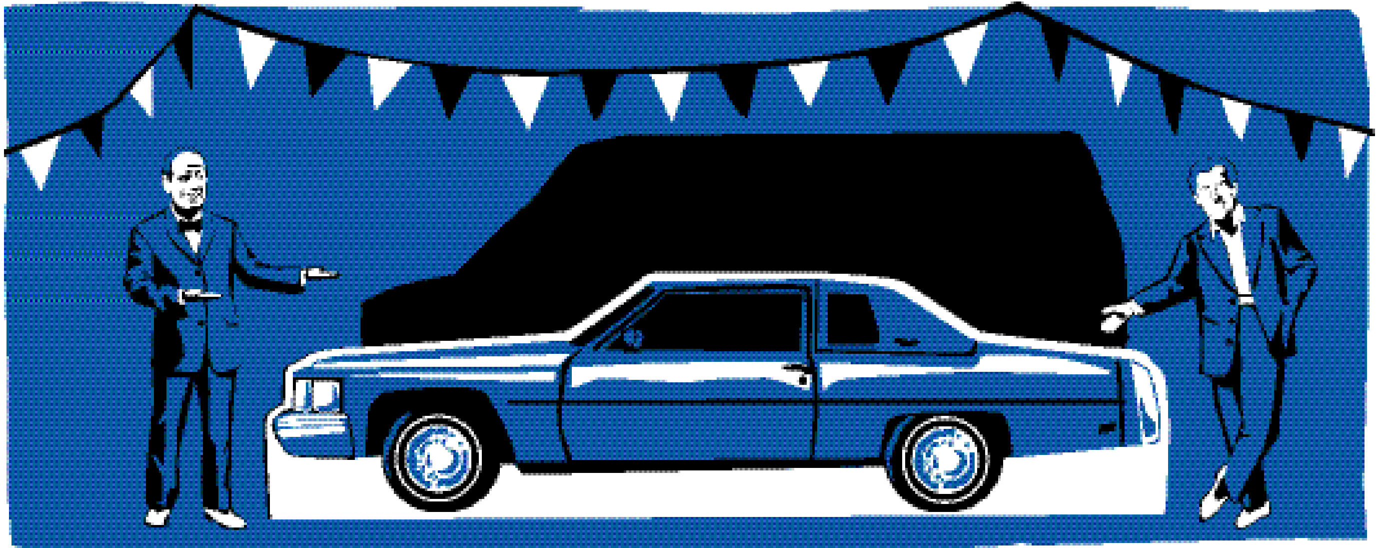
The Medicaid Showdown: A User's Guide

By Kai Wright Illustrations by ALR Design



The Diagnosis

Mo' Money, Mo' Money

If there's one thing everyone agrees on about Medicaid, it's this: The government health program for poor people is in critical condition.

It is New York's second-largest budget item, topped only by public education. It eats more than $13 billion in state funds, and $42 billion when all funding streams are counted. That amount has been growing—by an average of 9 percent a year throughout the 1990s. At the same time, Albany lawmakers are reckoning with a budget deficit approaching $5 billion and a court order for the state to pump billions more into public education.

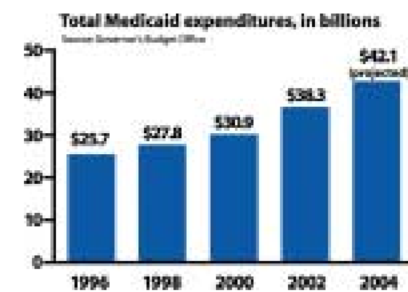
Last year, the governor threatened $1.6 billion in cuts, then won a brief reprieve by helping secure a temporary funding boost from Washington for state Medicaid programs nationwide. But that hike is set to expire this summer, and this year the U.S. House of Representatives is considering more than $2 billion in cuts. Meanwhile, county governments throughout New York State are threatening all manner of political revolt if they are not relieved of their burden to pay into the system—an estimated $6.6 billion this year. So Governor Pataki and the State Senate have vowed that 2004 will be the year they slay the Medicaid budget dragon.

The governor's office and those who agree with its assertion that Medicaid has become an "unaffordable burden" have derisively labeled our system the "Cadillac" of public insurance. They note that we spend three times the amount, per capita, that California does.

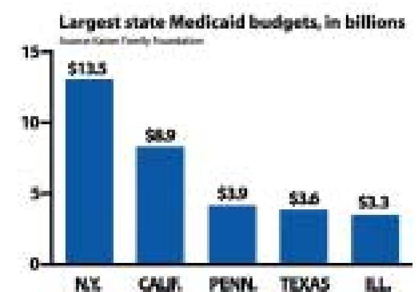
The health care industry and advocates for Medicaid's users look at the same numbers and see a different story. The industry points out that compared with other states, New York is home to a dramatically larger population of people who are the most expensive to care for—seniors and people with disabilities or chronic illnesses. Consumer advocates add that New York's Medicaid bill is high because this state, far more than others, leans on the program and its federal funding stream to cover a staggering menu of health-related expenses. In California, for instance, mental-health care is something counties must pay for out of their own funds; but in New York, we fold it into the shared cost of Medicaid. New York's bean-counters have also become so adept at transferring loosely related costs to the Medicaid system that the practice has turned into a verb—as in, we'd like to "Medicaid" the cost of graduate medical education (a proposal on the table this year).

But whatever the reason for the program's expense, there's no avoiding the political reality: In tough budgetary times, Medicaid's price tag makes it a prominent target. The question is no longer whether to tamp down New York's Medicaid costs, but how.

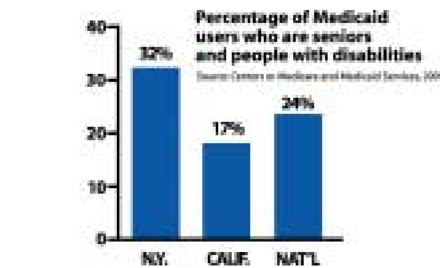
New York's Medicaid costs are skyrocketing.

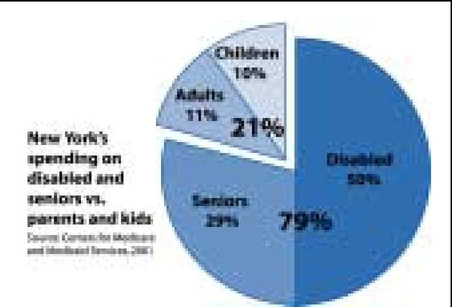


But do we have a Cadillac...



...or an ambulette?





The Treatment

Four Agendas Claim to Cure Medicaid's Ills

There's an easy fix to Medicaid's budget troubles, and it's one of the few proposals all four of the major

Unfortunately, the feds have their own ideas about how to fix Medicaid. The Bush administration wa gress, meanwhile, is now considering multimillion-dollar cuts to the feds' Medicaid contribution.

That leaves New York wielding its own budget knife. One popular reform scheme is a "preferred drug gaining power with pharmaceutical manufacturers. But doctors would have to get permission to prescr

It's also likely that the state will take over the cities' and counties' costs (of which New York City player wants to tie quite different strings to it.

Industry and government agree that some hospitals and nursing homes currently have too many because the hospitals have other priorities they care about even more: blocking any new taxes and

Consumer advocates will also likely be forced to choose which sacred cow to slaughter. The widely ly tough to maintain New Yorkers' relatively easy access to expensive long-term care.

Here's how the four main reform proposals now on the table differ

The State Senate

Control the cost of Family Health Plus. The program grew sixfold between 2002 and 2003. In response, the Senate plan would require copayments for services and start counting assets, rather than just income, to determine who qualifies. Any state takeover of local costs would be tied to these reforms.

Move kids out of Medicaid. In 1997, the feds created Child Health Plus to cover kids from working-poor families who didn't qualify for Medicaid. It offers fewer benefits than Medicaid, and is thus cheaper. The Senate plan would shift most kids from Medicaid into Child Health Plus.

Make Medicaid the "last resort" for long-term care. The Senate's Medicaid task force worries that too many people who can pay for their own care exploit loopholes to get on the public rolls. So the Senate would get rid of a rule that allows a person's spouse to refuse to pay for long-term care costs; more aggressively scrutinize assets when deciding whether an applicant for coverage qualifies; and promote a program in which consumers can use Medicaid in conjunction with private long-term-care insurance.

"Right size" hospitals and nursing homes. Industry and the state agree that some facilities can't stay full because they're too big for the communities they serve. The plan would shrink some, close others, and divert the funds to home-based care and assisted living.

The Governor

Rein in Family Health Plus. Governor Pataki echoes the Senate's focus on this program as a budgetary boogeyman. In addition to the added copays and asset test that the Senate proposes, the governor's plan would disqualify anyone in a government job or working for a business with more than 50 employees, and get rid of dental and vision coverage, among other belt-tightenings.

Move kids out of Medicaid. The governor also agrees with the Senate's goal of moving kids who qualify for Child Health Plus out of Medicaid. But the governor's plan would also cut funding for a program that contracts with nonprofits to help families complete the enrollment paperwork for all public insurance programs.

State takeover of long-term care costs. The governor proposes that the state take over local governments' costs, phasing in the shift over 10 years. But this takeover would be contingent on cost controls like a reduction in the reimbursement rate paid to nursing homes and tighter eligibility rules.

Tax the hospitals. Pataki wants to slap hospitals with a 0.7 percent tax on revenue—something the industry fought hard to get rid of in the early 1990s. The industry will likely gun hardest at this proposal, stressing the financial crises that hospitals already face. Indeed, the industry wants to see a boost in state aid.

players in this year's showdown rally around: Make Washington pay a greater share of the bill.

ants to block-grant the program, giving the states one lump sum payment and leaving them to make ends meet as they see fit. Con-

g list"—a limited formulary of meds doctors can prescribe—to discourage frivolous use of expensive drugs and give the state more bar-
ribe drugs not on the list, and there's disagreement between advocates and lawmakers about what sorts of protections consumers need.
pays the lion's share: 12 percent of the whole Medicaid pie). But while everyone agrees that a state takeover should happen, each

beds. They're less chummy, however, over how and where to "right size" the facilities. The state is likely to get its way on the fight,
d securing a boost in the rates they're paid for emergency care.
y used Family Health Plus is popular enough in Albany to withstand a fight, but protecting that pot of money may make it extreme-

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in their prescriptions for New York's ailing Medicaid budget.

The Industry

Represented by the Healthcare Education Project, a partnership of healthcare workers union SEIU 1199 and the hospital and nursing-home industry group Greater New York Hospital Association

Make managed care work right. The industry plan holds out hope that the state's previous budget fix, managed care, can still pay off. To get savings, the proposal says, we must simplify the process for signing up and staying enrolled, standardize the rules that govern hospitals' relationships with the plans, and expand the number of plans available for long-term care.

Control shrinkage of hospitals and nursing homes. The hospital and nursing home industries have conceded that some facilities are too big for the communities they serve. But they say any shrinkage needs to be managed, rather than left to the market. One bill in play would strategically cut nursing home beds, as long as the homes that give up beds are guaranteed they'll be first in line for any future expansion.

Get people to pay for their own long-term care. Industry agrees with the Senate and governor that more people could pay for their own care. So its plan also gets rid of "spousal refusal" and promotes Medicaid as a supplement to private insurance.

The Consumer

Represented by the coalition Medicaid Matters New York

Protect Family Health Plus. Advocates remind everyone that this program was largely conceived as a way to help ease the transition from welfare to work. Its growth, in this light, is a success. Copays will discourage use, they warn, and ultimately lead to more use of expensive emergency care.

Make Medicaid user-friendly. Every 12 months, Medicaid recipients have to prove they still qualify. Advocates say the process is cumbersome and wastes money by "churning" people in and out. Their plan argues that simplifying the process and adding translation services will reduce administrative costs and stabilize treatment, making it more likely that managed care's savings will materialize.

Get a better deal on pills. While the preferred drug list is a start, its promise lies more in reducing the needless use of expensive meds than bringing down the price the state pays. The advocates' plan urges the state to pool its drug purchases to get a lower price [see *City Limits*, April 2004] and to look into buying meds from Canada.

Put the money where it belongs—in care. Advocates have long been skeptical of the state's reimbursements to hospitals for patients who can't pay. There's little tracking of that money, and they want to see a closer, more public accounting. Similarly, they want the state to stop dumping unrelated budget items into the Medicaid well to get federal matching funds.

The Medicaid Challenge

Getting Signed Up

So you say you can't afford health insurance? You can just wait until your ailments become acute and go to the emergency room—a pricey choice made by most of New York City's 1.8 million uninsured. But the state also has four public health insurance programs that could help. Unfortunately, each has a different set of rules and processes for signing up and staying enrolled—you've got to be poor enough, and you've got to be able to prove it. Consumer advocates have long complained that this maze is Medicaid's primary problem, in terms of the money it wastes and the impact it has on care. The United Hospital Fund found that fewer than half of the people who signed up for Medicaid in 1998 managed to stay in the program for 12 straight months. Another recent study found the state could reduce the cost of enrolling kids by 40 percent if it simplified the process.

Who's eligible?

The Neediest Cases

If you're pregnant and make less than $18,624 a year; if you're disabled and make less than $7,908 a year; if your household makes less than $11,604 a year (for a family of four); or if you have no children but make less than $4,800...then congrats, you qualify for Medicaid.

The Working Poor

Now, if you make up to $28,284 a year (for a family of four); or you have no kids in your home, but make less than $9,312 a year…then it's Family Health Plus that you want.

The Children

And, finally, if you're an infant and your family of four makes less than $37,704 a year; or you're under 19 and your family of four makes less than $25,080 a year...then you're in Child Health Plus A—Medicaid, but for kids. Children in families with higher incomes can get into Child Health Plus B—which means paying a premium that can be as high as $45 a month, per child, depending on your income and family size.

How to prove it

With all that figured out, you're ready to sign up for health care—if you can prove you need it. Here's what you'll have to do:

Document all your sources of income. The state will then verify this, using your Social Security number.

Prove as many as 20 facts about yourself, including citizenship, housing costs and evidence that you aren't already insured. The city is trying to streamline this process as much as the state will allow. "There's no question it's improving," says Denise Soffel, a Community Service Society researcher, "but it's moving a bureaucracy the size of an elephant."

If you're on Medicaid, you'll need to help the state verify that you don't have any assets squirreled away. But when lawmakers set up Family Health Plus, they thought it silly for officials to hunt for secret assets among people with low incomes. So ironically, the more money you've got, the less documentation you have to provide.

Unless you're disabled or a senior, all New York City applicants must pick a managed care plan.

Repeat every year, or every six months if you also receive Social Security Insurance disability benefits.

What's at Stake?

Medicaid by the Numbers

1. Number of uninsured people in New York City: 1.8 million
2. Percentage of the city's uninsured who have full-time jobs: 60
3. Cost of an average prescription for Lipitor, the leading brand-name cholesterol drug: $275
4. Cost of the same prescription in Canada: $159 USD
5. Percentage by which Medicaid drug costs have risen in the last five years: 113
6. Drug industry 2001 lobbying budget in New York: $1 million
7. Percentage of New Yorkers who have private insurance for long-term care: <5
8. Average daily cost of staying in a nursing home: $200
9. Annual savings generated by transferring 1 percent of nursing home patients into community-based care: $25 million
10. Percentage of nonprofit, general-care hospitals in the city operating in the red in 2001: 37
11. Share of New York hospitals' annual income generated by Medicaid and Medicare: One-third
12. Number of jobs in New York's health care industry in 2002: 862,000
13. Percentage of all non-farm employment those jobs account for: 10
14. Cumulative value of wages generated in New York by Medicaid spending in 2001: $11.7 million

Sources: 1-2: United Hospital Fund; 3: Drugstore.com; 4: PharmacyChecker.com; 5: NYS Dept. of Health; 6: Common Cause New York; 7: Greater New York Hospital Association; 8: New York State Senate; 9: Center for Disability Rights; 10-11: Greater New York Hospital Association; 12: United Hospital Fund; 13: NYS Dept. of Labor; 14: Families USA.